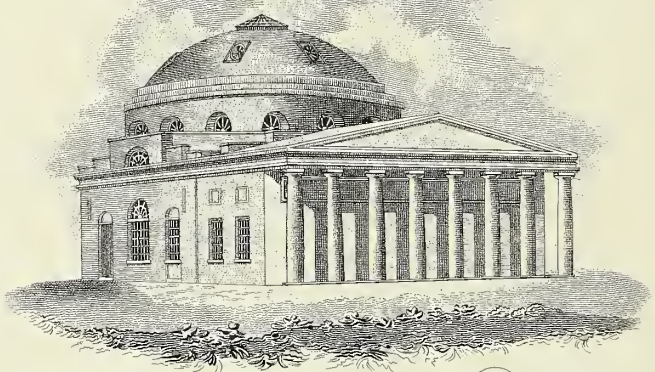




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NUMBER 1

## BLOOD-CONTAINING URACHAL CYST SIMULATING ACUTE APPENDICITIS†

### Report of a Case

GEORGE C. RASCH, M.D.\*

*Indianapolis*

THE URACHUS is the involuted upper portion of the fetal bladder. Normally it becomes narrowed and persists as a fibrous cord located between the transversalis fascia and peritoneum, and extending from the apex of the bladder to the posterior aspect of the umbilicus.<sup>1</sup> According to Begg,<sup>2</sup> the epithelial canal of the urachus is never completely obliterated by fibrous tissue. As long as a portion remains patent a cyst may form.<sup>3</sup> Why such cysts occur is not always clear. Colston<sup>4</sup> has suggested that secretory activity of the epithelial lining of the fibrous cord may be a factor in cyst formation. Urachal cysts and sinuses have been classified as follows:

a. cysts between umbilicus and bladder,

- b. patent urachal sinus draining at umbilicus but blind at the bladder end,
- c. patent urachal sinus extending from bladder and ending blindly at umbilicus,
- d. patent urachus extending from bladder to umbilicus and draining urine.<sup>5</sup>

They have been reported to contain urine, pus, cholesterolin, serous transudate, mucoid material, blood or fibrin.<sup>6</sup> Many cysts are probably not discovered because of the lack of symptoms.<sup>7</sup> Some, however, become infected and present as tender suprapubic masses with fever and gastrointestinal disturbances. Such infected cysts may be treated by incision and drainage with secondary removal, or in some cases by primary excision.

The following case is one of a urachal cyst containing blood which was discovered on abdominal exploration carried out because the clinical picture simulated acute appendicitis. A history was obtained of trauma to the abdomen which may be the explanation for the presence of the blood found in the cyst and the subsequent

†Reviewed in the Veterans Administration and published with the approval of the Chief Medical Director. The statements and conclusions published by the author are the result of his own study and do not necessarily reflect the opinion or policy of the Veterans Administration.

\*From the Cold Springs Road Veterans Hospital, Indianapolis, Indiana.

appearance of inflammation and clinical symptoms.

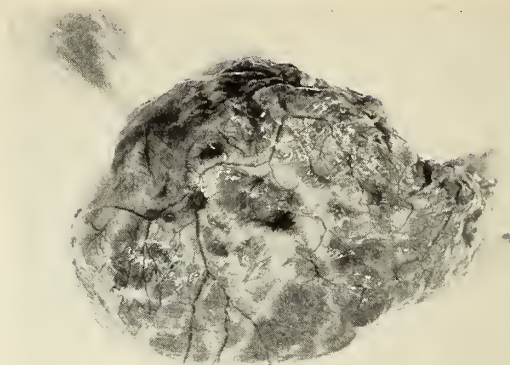
### *Case Report*

F.F., a white male aged 24, was admitted to the Cold Springs Road Veterans Hospital on November 8, 1950, complaining of persistent right lower quadrant pain of three days duration. The pain began about the umbilicus and then shifted to the right lower quadrant. The patient had noted some nausea but no vomiting. Appetite had remained fairly good. A rather typical history of gas stoppage syndrome was obtained. No relief from the pain was obtained by bowel movements. On admission the patient stated that there had been no previous similar attacks of pain. Physical examination was negative except for examination of the abdomen. Marked tenderness to palpation was present slightly medial to McBurney's point in the right lower quadrant. Rovsing's sign was positive. Slight rebound tenderness was noted on palpation of the left lower quadrant. Rectal examination was negative. The temperature on admission was 99.8°F. The leukocyte count was 11,500 with 77 per cent neutrophils. Urinalysis was negative.

The patient was operated upon with a diagnosis of acute appendicitis. A spinal anesthetic was administered. During preparation of the abdomen a mass was palpated to the right of the umbilicus. The contemplated McBurney incision was therefore abandoned and the abdomen was opened through a right paramedian incision. Upon opening the peritoneal cavity an orange-sized cystic structure was found lying in the midline and attached firmly to the posterior aspect of the umbilicus by a fibrous stalk. The cyst was located between the transversalis fascia and peritoneum. The omentum was attached to the cyst in several places. A fibrous cord extended from the distal end of the cyst to the apex of the bladder. The cyst was excised. A small area denuded of peritoneum remained beneath the umbilicus. The distal fibrous cord did not appear grossly to be patent. After removal of the cyst a normal appendix was removed. The terminal ileum and mesentery were inspected and no abnormalities found. The abdomen was closed without drainage.

The patient made a satisfactory recovery complicated only by a post-spinal headache. Careful

**Figure 1**



**Urachal Cyst—lateral view**

questioning of the patient after operation disclosed that about two months before admission he had suffered a severe hammer blow near the umbilicus. At that time he had periumbilical pain for about six hours. No other symptoms had been noted. Two months after surgery the patient had no abdominal symptoms and examination was negative. The abdominal wound was nicely healed.

The excised specimen was a rather large cyst-like structure measuring 4.5 x 5.5 x 6.5 cm. showing a glistening membrane covering the surface which looked like peritoneum. A large amount of chocolate-colored fluid material resembling blood was contained within the cyst. The wall of the cyst seemed to be mostly connective tissue. Microscopic examination of sections through the cystic mass showed multiloculated cysts, the cavities of which were lined by a very low squamous type of cell. The cells resembled endothelial or mesothelial cells rather than epithelium. Occasionally the cells were slightly higher and resembled cuboidal epithelium. The intervening tissue consisted of connective and fatty tissue in which there were frequent accumulations of inflammatory cells, mainly lymphocytes. The cyst cavities varied enormously in size and shape. Sections through the brown material showed it to consist of partially degenerated blood. The diagnosis was multilocular cyst, region of urachus. The appendix was normal, grossly and microscopically.

### DISCUSSION

This patient had no abdominal symptoms prior to the injury to his abdomen. He then

had pain for several hours and two months later an attack of abdominal pain with gastrointestinal symptoms resembling acute appendicitis. This course would seem to be explained by the injury with subsequent bleeding and inflammatory changes within the cyst.

#### SUMMARY

A case is reported of a urachal cyst containing blood with mild inflammation causing symptoms simulating acute appendicitis. The cyst was treated satisfactorily by excision.

(The pathological examination was performed by Dr. David Rosenbaum.)

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## TOWARD OPTIMAL NUTRITION

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*Indianapolis*

ATTAINMENT of a state of optimal nutrition is a goal of those interested in maintenance or restoration of health. Optimal signifies best possible and as related to diets implies the planned ingestion of over forty known essentials<sup>1</sup> and minimal quantities of substances thought to be deleterious. Obviously, there can be no single optimal diet because enzyme systems of individuals vary. However, many nutritional faults which can be avoided are known and an approach to the best possible nutrition under existing circumstances is desirable.

Such descriptive terms as liver protective and artery protective regimens are indicative of the improbability of the ordinary diet. It is disturbing to consider oneself eating in a manner which is not liver protective or artery protective. Not long ago the occurrence of cirrhosis of the liver was considered an unpredictable catastrophe. From the demonstrations of nutritional cause and effect in lower animals, it is now believed we reap what we deserve. Years of dietary indiscretion take their toll in obesity, fatty or cirrhotic liver or other degenerative dis-

eases. The "improvability of our internal environment" (Sherman<sup>1</sup>) is beginning to be appreciated and ample rewards may accrue to those who plan their food intake to the best of present knowledge.

An optimal diet is quite different from an adequate one. Prescribing so many grams of carbohydrate, protein and fat with attention to the vitamin requirements will not insure an optimal diet. There is too much left to chance as to the source of carbohydrate, protein and fat chosen to make up their respective allotments. For instance, used in small quantities, there is little reason to be critical of sugar as a food. Three hundred years ago it was not available<sup>2</sup> and in colonial times it has been estimated that the average consumption of sugar was about five pounds per person per year.<sup>3</sup> Now the figure is 112 pounds per person per year.<sup>3</sup> Enzymes of the human body developed over many thousands of years without this large intake of sugar. When about 600 calories per day are thus allotted, the forty or more essential nutrients need to be provided by other foods.



These required nutrients are difficult to supply if the carbohydrates also include a large quantity of starches of the character of pies, cakes, soda crackers, potato chips, pretzels, noodles, dumplings, et cetera. Since its enrichment, white flour can only be criticized according to our prejudices concerning the importance to nutrition of essential unsaturated fatty acids, vitamin E, trace minerals and the first grade protein<sup>1</sup> which were in the original wheat berry, as compared to the lack or availability of these substances in other foods.

Deficiency of thiamine is associated with beriberi, a congestive heart failure, peripheral neuropathy and Wernicke's encephalopathy which are customarily treated by administration of thiamine. Fats have a sparing action on thiamine requirement<sup>4,5,6</sup> and presumably a high intake of carbohydrate increases thiamine needs. Possibly restriction of starches and sugar would be of value in treating the more resistant thiamine deficiencies. A diet low in free sugar has been reported by Portis<sup>7</sup> to result in clinical improvement in cases of chronic fatigue due to emotional stress. Also, starving individuals rarely show evidence of specific vitamin deficiencies.<sup>8,9</sup> Conversely, when starches and sweets constitute a high percentage of the diet, it may be impossible to maintain a state of good nutrition at any body weight.

Many causes for dietary fatty livers have been discovered,<sup>3,10</sup> including excessive intake of carbohydrates, cholesterol, biotin, thiamine, niacin, riboflavin and cystine; or deficiency of choline, methionine, essential fatty acids, pantothenic acid and pyridoxine. In the treatment of fatty liver, a high carbohydrate, high protein, low fat and high vitamin diet is often used. It may be of importance, however, that the carbohydrate intake not be composed largely of sugar and white starches, the protein of poor quality, the fat from foods rich in cholesterol or the vitamin sources of unbalanced synthetic mixtures.<sup>10</sup>

Dietary hepatic injury presumably impairs ability of the liver to inactivate estrogenic hormones. However, metabolic functions of the liver are not such that they are all normal until they are completely abnormal. In work done on vitamin B deficient rats, the Biskinds<sup>11</sup> have reported inability to inactivate estrogens by histologically normal appearing livers. Excessive

estrogen, a failure of the liver to inactivate estrogen or lack of rhythmic fluctuations in estrogen levels are among the explanations sometimes cited for the occurrence of uterine fibroids, ovarian cysts, chronic cystic mastitis and anemias due to excessive or frequent menstrual flow. Exclusion from the diet of the germ of wheat should also be considered a factor if the work of Levin and Burns<sup>12</sup> is confirmed, demonstrating that wheat germ oil has endocrine effects of progesterone and testosterone. These hormones both possess antifibromatogenic properties.<sup>13</sup>

A few examples will suffice to illustrate the importance of the quality of dietary proteins on a basis of their essential amino acid content. Lysine is an amino acid needed in regeneration of skeletal muscle.<sup>14</sup> Apparently animals will develop only to the extent to which their diet allows them to incorporate the normal amount of this material into body proteins. Then the animal will stop growing rather than produce lysine poor tissues.<sup>1</sup> An excessive intake of the amino acid methionine increases the size of the kidneys, increases the level of plasma globulin and liver nitrogen, seemingly at the expense of skeletal muscle nitrogen.<sup>14</sup> An imbalance of amino acids in the diet can deplete one tissue while building another. According to Allison,<sup>14</sup> the proper proportion of essential amino acids must be absorbed simultaneously if tissue protein is to be synthesized. The delayed absorption of even one essential amino acid may prevent retention of others and result in wasteful burning rather than tissue building. Therefore, proteins should be derived from a wide variety of sources to assure presence of optimal amounts of all essential amino acids.

Our knowledge relative to fats in the diet is limited. If it is necessary to prescribe a low fat diet, the composition of that small amount of fat deserves attention. Thus the human body can manufacture cholesterol and there are indications that a low intake of this material may at times be advantageous.<sup>8,15</sup> Cholesterol is found in fats of animal origin.<sup>15</sup> On the other hand, small quantities of certain unsaturated fatty acids must be supplied by food since present indications assign to the liver ability to desaturate to the extent of one unsaturated double bond, but not two, three or four.<sup>10</sup> To supply these materials, the fat intake could include fresh

oils of vegetable origin or fish oils. These oils must be fresh because rancid fats are highly toxic. Wheat germ oil quickly becomes rancid and this is one of the reasons whole wheat flour is difficult to store. It is conceivable that slight rancidity develops in the fat of meats during long periods of storage.

Sometimes the beginnings of disease may be traced to a pattern of faulty food habits such as omitting breakfast, eating a light lunch and a substantial, starchy evening meal. Obesity, biliary dysfunction and constipation often result. Nutrient materials with which the body has to work normally enter only by way of the mouth. It makes considerable difference what quantities of the various foods are ingested. Adaptive mechanisms cannot completely erase the effects of dietary excesses and deficiencies nor always deal successfully with toxic materials which may find their way into the gastrointestinal tube. Some substances now under investigation for toxicity<sup>16,17</sup> are chemical additives used in preserving and processing of foods, or synthetic, organic pesticides as parathion and D.D.T. The toxic nitrates and nitrites are found in certain well waters<sup>18</sup> and in corning extract.<sup>19</sup> Some processes not in themselves harmful have secondary effects. Thus the sulfuring of fruits results in the loss of vitamin B<sub>1</sub> content due to the destructive effect of sulfite on thiamine.<sup>5,20</sup>

The state of nutrition of the individual and his degree of physical activity influence the level of carbohydrate intake advised. For a moderately active adult person, perhaps an optimal diet should supply over 80 grams (Strang's<sup>21</sup> estimate of a liberal minimum quantity) and less than 300 grams of carbohydrate daily, using whole grain cereals and a variety of fruits and vegetables. Proteins in amounts of about 1 gram per kilogram of ideal weight<sup>21</sup> should be derived from several sources, including eggs, meat, poultry, fish and milk. If desirable, the cholesterol intake is minimized by cutting away the fat of meat and avoiding lard, cheese, cream, butter, organ meats, oysters and egg yolk.<sup>15</sup> To supply the fat requirement including unsaturated fatty acids one may use corn and wheat germ oils, vegetable shortenings, oleomargarine, cod liver oil, olives, olive oil, avocado, peanut oil, nuts and nut butters.<sup>15</sup>

When guiding a patient's choice of food, the practical effects of the advice to that person

must be considered. The fitness of food is ordinarily judged by whether it appears and smells "appetizing" and tastes "pleasant" on the tongue. Some may consider it cause for psychologic trauma to prohibit food which meets these requirements though lacking in other recommendations. Psychologic trauma might be said to parallel the extent of mental conflict. When a habit is broken, mental conflict is minimized if one is convinced of the logic of the amendment.

At present, the average American diet seems to necessitate considerable supplementation by patent tonics and multivitamins. Either these preparations are unnecessary for general consumption or there should be more public enlightenment concerning how to nourish the body as well as satisfy taste buds on the tongue.

Good nutritional habits are attained only by positive effort. Optimal nutrition depends upon optimal dietary intake. Such a regimen can be tailored to the individual and remain quite flexible. It need not involve the rigors of such therapeutic restrictions as the Sippy diet, low sodium diet and others now widely accepted. Careful dietary planning is a useful medical tool which will increase in importance as the advance of knowledge in the basic sciences permits approach to an optimal nutrition.

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#### SUGGEST MASS SCREENING TO DETECT EYE DISEASE

Mass screening of persons for early detection of glaucoma was suggested by Drs. Solomon S. Brav and Herbert P. Kirber, of Philadelphia.

The results of such a test on 10,000 persons have shown that the incidence of undiscovered glaucoma in the general population is approximately two percent, the doctors reported in the Nov. 17 *Journal of the American Medical Association*.

Their study, consisting of persons over 40 years of age, was made at large industrial plants. Of the 10,000 persons examined, 84 showed definite glaucoma, 69 early glaucoma, and 71 were borderline cases, a total of 224 or 2.24 percent. An additional 100 persons were kept under further observation as possible candidates for the disease.

If caught in time and proper control methods instituted, glaucoma can be arrested. Unhampered progression leads to blindness.

The doctors pointed out that mass screening of the population has been applied for the early detection of diabetes, tuberculosis, cancer and other chronic diseases.

They suggested that the great majority of the population could be reached for such an eye examinaion if it were made part of routine physical examinations in industry, or by the creation of a specialized agency which would devise plans for such mass screening.



# QUINIDINE TREATMENT OF VENTRICULAR TACHYCARDIA FOLLOWING ACUTE CORONARY OCCLUSION

## A Case Report

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and RICHARD H. OPFELL, M.D.  
*Indianapolis*

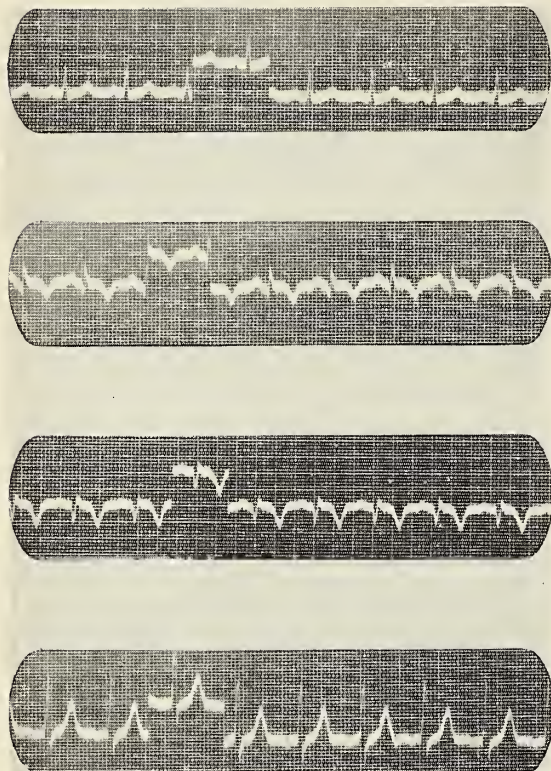
THE reluctance of many physicians to administer quinidine intravenously in ventricular tachycardia and other arrhythmias is largely attributable to apprehension concerning the attendant dangers. It is our belief that the hazards involved, when weighed in the balance against the fact that the condition of many patients with arrhythmias is already critical, are of lesser import, and must be disregarded in selected cases. Paroxysmal ventricular tachycardia is particularly common in the course of acute myocardial infarction.<sup>1</sup> If allowed to persist unabated, the decreased diastolic filling resulting from the tachycardia is often enough to throw the already severely damaged myocardium into irreversible failure. Continued paroxysmal ventricular tachycardia may also be the precursor of fatal ventricular fibrillation.<sup>2</sup> During intravenous injection of quinidine, it is possible to observe progress of treatment with the direct-writing electrocardiograph, and stop injection immediately if reversion takes place or if any threatening disturbance in the cardiac mechanism occurs. For these reasons, a case history of a patient with ventricular tachycardia following acute coronary occlusion, who was successfully treated with quinidine lactate\* intravenously, and subsequently maintained on oral quinidine sulphate, is presented.

\*The quinidine lactate used was furnished through the courtesy of Dr. Kenneth Kohlstaedt of Eli Lilly and Company, whose advice regarding administration of the drug was invaluable. Quinidine gluconate (Lilly) is now available; quinidine lactate is no longer available.

### CASE REPORT

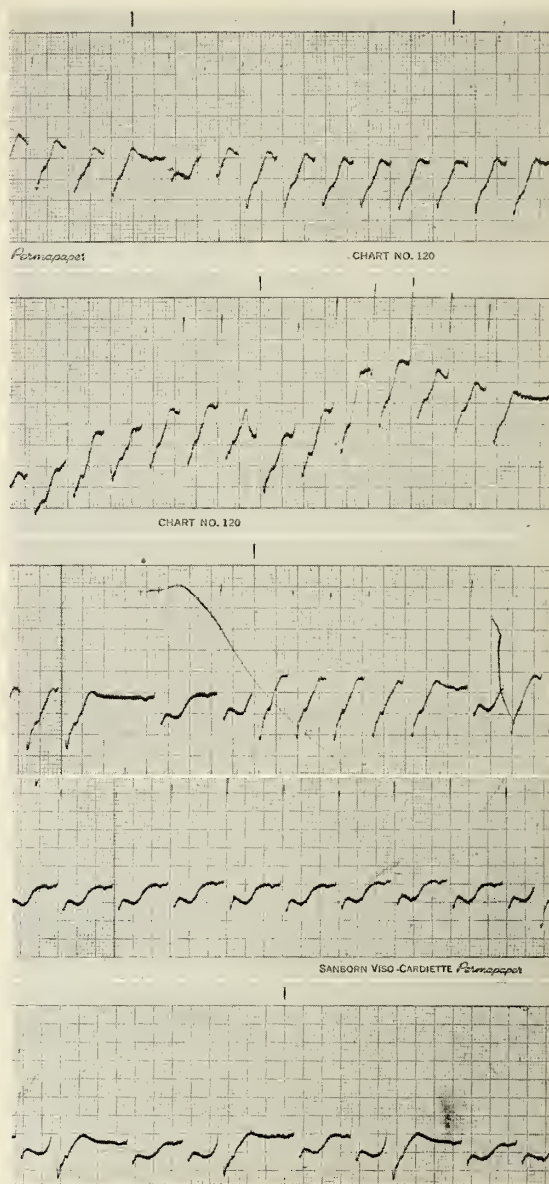
W. P., a 44 year old man, after 2 to 3 months of intermittent retrosternal distress, awakened on the night of May 10, 1950, with severe pain in the retrosternal area and epigastrium with some radiation to the back, vomiting, profuse perspiration and dyspnea. He was still suffering from retrosternal pain when he was first seen by one of us (R.U.L.) on the afternoon of May 12. Physical examination revealed a somewhat dyspneic, stocky, white male who was walking about but was obviously somewhat uncomfortable due to his retrosternal distress. The temperature was 98.6, the blood pressure 105/80 and the pulse 80. Numerous rales were heard in both bases posteriorly. A leukocyte count was 11,600. The sedimentation rate was 18 millimeters in one hour. The electrocardiogram (Fig. 1) demonstrated the characteristic Q2T2 and Q3T3 pattern of posterior coronary occlusion. Roentgenogram of the chest, taken on May 15 in the hospital which he had entered on May 12, showed great enlargement of the heart to the right and left and striated infiltration in the lower two-thirds of the left lung field, which was regarded by the roentgenologist as representing either pulmonary passive congestion or pneumonia. The latter possibility, coupled with fever of 101 degrees, led to treatment with 300,000 units of penicillin intramuscularly daily. Other measures consisted of oxygen, demerol, a low salt, low cholesterol, 1,200 calorie diet, 60 grains of ammonium chloride daily, 4 salyrgan and theophylline tablets daily for two consecutive days each week, and 1.0 cc. of thiomerin subcutaneously every second day.

Fig. 1



Tracings taken May 12, 1950, demonstrating the pattern of posterior coronary artery occlusion. Limb leads 1-3, precordial lead CF4.

Fig. 2



Tracings taken between 7:30 and 8:00 P.M. of May 18, 1950. Lead CF4 was the only lead of this series. Strip A was taken just before intravenous quinidine was begun; strip B during the first seconds of the injection; strip C after half the injection had been completed; strip D at the conclusion of the injection; and strip E about 10 minutes after the conclusion of the injection. Note decrease in rate from 170 to 100 (roughly) during the injection.

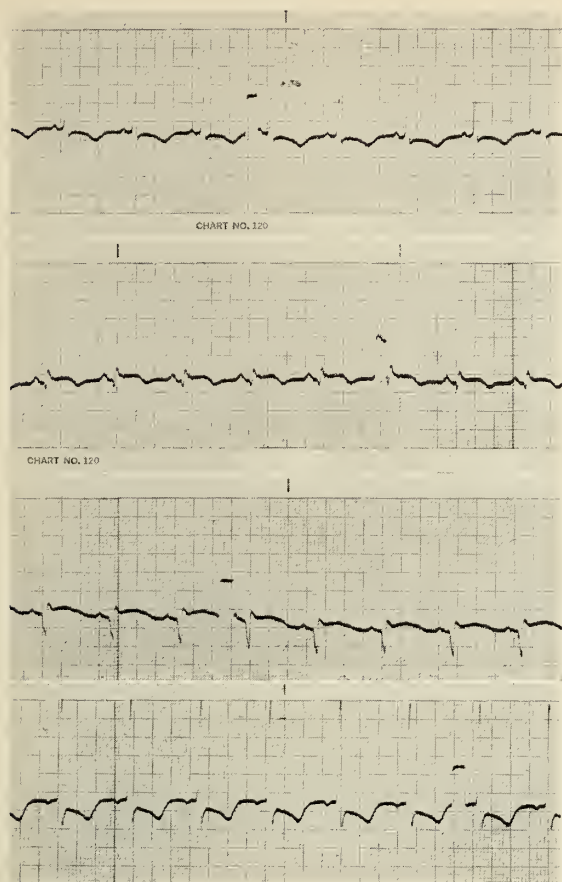
The pain in his chest persisted. On the afternoon of May 17 it was noticed that his apical and radial rates were approximately 150. On the morning of May 18 it was found that his cardiac rate had increased to the neighborhood of 180. The electrocardiogram of May 18 (Fig. 2) demonstrated the presence of ventricular tachycardia. At about 6 P.M. one 3 grain tablet of quinidine sulphate was given orally, but blood pressure readings were 104/58, 110/65 and 90/65. The patient became quite weak, his voice became faint, his feet became cold, and there was considerable diaphoresis. Because of this state of what seemed to be shock, one of us (R.H.O.) reported that the condition of the man was so grave that he would in all probability die unless intravenous quinidine were given.

At about 7:30 P.M., with the patient's heart rate at approximately 180, quinidine lactate was administered as recommended by Herrmann and Hejtmancik.<sup>3</sup> Quinidine lactate is supplied in ampoules of 0.65 gm. dissolved in 10 cc. of

sterile saline. The contents of the ampoule were mixed with 40 cc. of 5 per cent glucose and given intravenously in approximately 20 minutes. One of us (R.H.O.) injected the drug, the laboratory technician obtained the electrocardiographic tracings with the direct-writing



Fig. 3

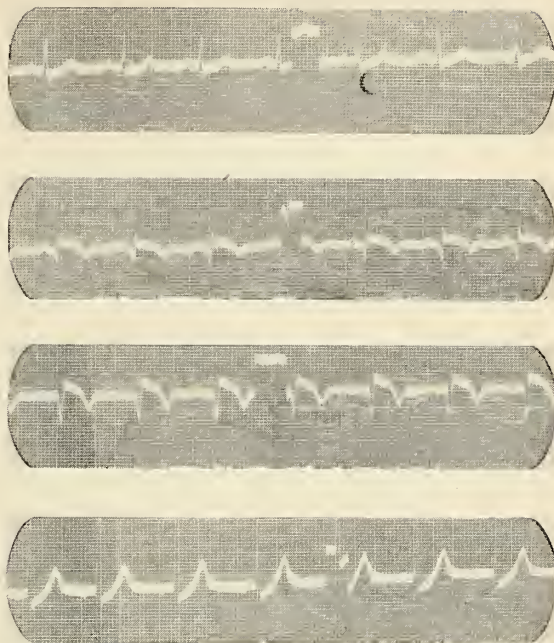


Limb leads 1-3, precordial lead CF4 taken on May 19, 1950, the morning after quinidine injection. Auricular and ventricular rate 80, sinus rhythm.

machine, and one of us (R.U.L.) observed the patient and the tracing for beneficial results and dangerous manifestations. Within 5 or 10 minutes after the completion of the injection, the patient stated that he felt stronger and that his feet were no longer cold. It was also noticed that his voice was no longer faint. The pulse was 90-100 and was quite irregular.

Study of strips a, b, and c of Fig. 2, before, at beginning and half-way point of the injection respectively, reveal that the ventricular rate, which was about 160-170 before the injection, had decreased to the vicinity of 140 after one-half the contents of the ampoule had been injected. Strips d and e, at the conclusion of and ten minutes after the conclusion of the injection respectively, indicate that the rate had been slowed to 90-100, but that sinus rhythm had not been produced. On the next morning, May 19, without further injection of quinidine,

Fig. 4



Tracings taken at the office on July 11, 1950. Limb leads 1-3, CFIV. Demonstrate ample residual evidence of posterior coronary occlusion.

a sinus rhythm with an auricular and ventricular rate of 80 was present (Fig. 3).

On the morning of May 19, the patient stated that he felt fine. His pulse was 84 and the rhythm was regular. Blood pressure was 80/60. By May 25 he had improved to such an extent that all medication was discontinued, with the exception of dicumarol and a maintenance dose of 3 grains of quinidine sulphate three times daily orally, which had been started on May 18. Dicumarol was discontinued on June 8, oral quinidine on June 13, the day of his dismissal from the hospital. The low fat, low cholesterol diet was maintained. He walked into the office on June 26, and was asymptomatic and without physical findings. The electrocardiogram of July 11 (Fig. 4) demonstrates the Q2T2, Q3T3 pattern, with close similarity to that of May 12 (Fig. 1).

#### GENERAL DISCUSSION OF TREATMENT WITH QUINIDINE

*Clinical Use:* Parenteral administration of quinidine is indicated when:

1. The patient cannot take medication by mouth due to vomiting or unconsciousness.

2. In the presence of very rapid heart action, especially ventricular tachycardia.

It is imperative that the therapeutic effect of quinidine be obtained as quickly as possible. Marked palpitation, dyspnea, vomiting, and a shock-like state in patients with ventricular tachycardia are signs that the intravenous administration of quinidine may be required as a life-saving measure.

*Contraindications:* The only absolute contraindication to the use of quinidine is the known presence of an idiosyncrasy or hypersensitivity to this alkaloid or other derivatives of Cinchona. The dangers of its parenteral use are increased in the presence of A-V block or in the absence of auricular activity. The administration of quinidine is more hazardous in patients with extensive myocardial damage than it is in persons with a normal heart who have a cardiac arrhythmia. Occasionally a cardiac arrhythmia may have been produced by digitalis intoxication, and the use of quinidine in this situation is extremely dangerous because the cardiac glycoside may already have caused serious impairment of the intracardiac conduction system.

#### ADMINISTRATION

*Intramuscular Route:* When vomiting, unconsciousness, et cetera, preclude the oral use of the alkaloid and the patient's condition is not critical, quinidine gluconate should be given intramuscularly. Its effect will be apparent within 30 minutes and maximal results will be produced within 3 hours.<sup>4,5,6</sup> As much as 0.5 gm. quinidine gluconate has been given into the gluteal muscle without producing irritation. The amount of each dose must be gauged by the effect of the preceding one. If the patient is under close observation the injection of 0.4 gm. of quinidine gluconate can be repeated as often as every 2 hours. Administration must be stopped at the first sign of the restoration of normal rhythm or upon the appearance of toxic manifestations. The effective dose must be determined for each patient. Some authors prefer intramuscular to intravenous therapy, claiming that the intramuscular route is less dangerous.<sup>7</sup> Some feel that quinidine given intramuscularly is not subject to the control of the intravenously given preparation, which can be discontinued at

the first sign of toxicity or at the time of reversion if the drug is given slowly.

*Intravenous Route:* When the condition of the patient warrants intravenous administration, constant observation of the patient is imperative. The solution should be injected at the rate of 1 or 2 cc. per minute. It is advisable to dilute 10 cc. of the gluconate to 50 cc., using 5 percent glucose. The cardiac rate should be observed by auscultation at the apex. During the injection frequent or continuous electrocardiograms are desirable, being helpful in the detection of a change in rate or rhythm. Armbrust and Levine stated that "the intravenous administration of quinidine was successful in 20 out of 31 cases, these being the more desperate cases. Oral administration of quinidine was successful in 46 of 57 episodes. In general, if it appears that the patient is likely to succumb in minutes or hours the intravenous route is preferable, whereas if he is likely to survive for days the oral method might be employed. Maximum single effective oral doses required for reversion in persistent paroxysmal ventricular tachycardia varied between 0.2 and 2.5 grams. The total amount which was required to produce reversion varied between 0.2 and 45.8 grams but the usual amount was between 0.2 and 8 grams."<sup>8</sup> A maintenance dosage of oral quinidine after the arrhythmia has been abolished is highly desirable and almost imperative to prevent return of the paroxysms. Some patients are controlled with small doses of 0.2 gm. every 6 hours, while others may require larger doses more frequently administered. Therapy may have to be maintained for days or weeks.

Armbrust and Levine<sup>8</sup> state "Single intravenous doses varied from 0.2 to 1.5 grams. In six of the successful cases treated by the intravenous route, reversion was not effected on the first intravenous dose but was accomplished on the second. In 4 of the 11 cases which resulted fatally, death was due to quinidine toxicity. However, all fatalities occurred in patients who were in extremis. In general, it is of little importance to estimate the total amount of the drug employed. The significant factor is the largest single dose which is required to effect reversion."

Gold states "A rate of 230 a minute fatigues the heart and damages the circulation. The first



step is to try to reduce the speed of the heart to a more favorable rate, usually to about 120 or 110 a minute. This may already be a sinus rhythm, or still an idioventricular rhythm. There is no evidence that the latter at a rate of 110 is any less favorable to the circulation than a sinus rhythm of 110 a minute. The reason one does not aim to abolish the ventricular tachycardia directly is the fact that one does not know in advance what remains when the idioventricular rhythm is suppressed. One may find arrest of the auricle in which no sinus discharge is produced, or A-V block so that the sinus impulse cannot get through to the ventricle. The result is cardiac standstill which may prove disastrous. It is noteworthy that even such a hazardous state of affairs is not always fatal, and after an unpleasant period of time, the heart resumes a beat from some focus."<sup>9</sup> Herrmann states "we have been reluctant to administer quinidine after the QRS complex has been prolonged over 25 per cent."<sup>3</sup>

*Toxic Effects:* Quinidine given parenterally may cause cinchonism—namely, tinnitus, vertigo, blurred vision, photophobia, diplopia, scotoma, dilated pupils, headache, fever, skin rash, vomiting, diarrhea, abdominal pain, excitement and mental confusion.<sup>9</sup>

#### COMMENT

It is believed that an error was made in the management of this case which might have proved to be disastrous. The ventricular tachycardia should not have been allowed to remain untreated so long. It is entirely possible that it began on May 17 when the pulse was found to be 150. It would have been more logical to have obtained an electrocardiogram on that date instead of on May 18. By 6 P.M. of May 18 the patient was in shock and nearly moribund. In our case it seemed to augur well for the eventual recovery of the patient when, after 0.65 gram of quinidine lactate had been administered intravenously, the rate decreased from about 170 to 110 while the injection was in progress. (See Fig. 2) Within 10 minutes after the injection was begun the distortions of the electrocardiogram mentioned by Armbrust and Levine<sup>8</sup> had become manifest; they were still more pro-

nounced shortly after the injection was completed. That these abnormalities seemed to be of no particular importance is attested to by the favorable outcome of the case, and the turn of events seems to confirm the remarks in this connection quoted above from the writings of Gold.<sup>9</sup> The regular sinus rhythm to be observed on the electrocardiogram taken the morning after the injection is a further testimonial to the efficacy of the drug, as is the state of well-being of the patient immediately after the injection and throughout the remainder of his hospital stay and in the months thereafter. He was known to be alive, at work and in apparent good health in June of 1951. As to the eventual prognosis in the aggregate of cases, Armbrust and Levine state that "in 42 patients in whom ventricular tachycardia complicated an acute myocardial infarction 28 or 64% were dead within one month after the attack of tachycardia. Ten lived 2 years or longer; the longest period of survival was 11 years."<sup>8</sup>

#### CONCLUSIONS

1. A case of ventricular tachycardia following acute coronary occlusion is presented.
2. The patient was treated successfully with quinidine lactate administered intravenously; the direct-writing electrocardiograph was used to govern the amount of the drug injected. Oral administration of quinidine sulphate was employed as maintenance therapy and no further episodes of ventricular tachycardia occurred.
3. It is believed that the dangers of using quinidine in suitable cases have been overestimated in the past, and are not comparable to the hazards of omitting the use of the drug in those cases. The hazards mentioned are reduced by controlling dosage as described. The salutary effects of the drug in a case of the type reported are such that the possible disadvantages should not be allowed to influence the physician unduly.

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## BREAST FEEDING\*

RAMON B. DuBOIS, M.D.

*Lafayette*

THE endocrine physiology of the breast presents an interesting picture. An understanding of how the ductless glands bring about the development of the breasts and the production of milk is of practical use to the physician. Successful breast feeding is dependent on the activities of the ductless glands. Proper management of the mother who is interested in nursing her baby can only be brought about when we make practical use of our knowledge of endocrine activities.

In the human embryo at the sixth week a ridge of epidermis, extending the full length of the trunk on either side, appears. This is called the milk streak. At the ninth week this streak atrophies, except in the pectoral region where basal cells appear and form the nipple bud. In the third month squamous cells invade the

nipple bud, forming a core, and basal cells sprout downward to form the ducts. The nipple is gradually everted by growth of underlying connective tissue. This development is the same in males as it is in females. It is possible that the adrenal gland acts as a primitive sex gland in the development of embryonic breasts.

Both male and female breasts show physiological activity shortly after birth. There is a temporary increase in the size of the breasts, with the production of witch's milk in some cases. This hypertrophy is stimulated by the hormones of late pregnancy, maternal and placental in origin. Estrogen, as well as lactogenic hormone, has been found in the blood stream of newborn babies, and it is believed that the successive stimulation with estrogen and lactogenic hormone explains the activity of the breasts in newborns.

\* Presented at the annual meeting of the Ninth Medical District of Indiana, at Lafayette, on May 24, 1951.



The period of quiescence in the mammary gland in childhood parallels the similar quiescent period of the gonad.

In girls, adolescent changes in the breast begin between the ninth and thirteenth year. The duration is roughly three to five years. The nipple and areola increase in size and there is a smooth, dome-like swelling. The increase in size is due to the growth of fibrous stroma and fat, and there is an increase in the length of the duct tree. At this time lobular buds appear at the ends of the ducts. This growth is stimulated by the production of estrogen from the ripening ovarian follicles. It has been observed that there is never lobule formation at the ends of the ducts prior to the advent of corpus luteum. A production of estrogen beyond physiological limits during adolescence, which is sometimes seen in tumors of the ovary, leads to a stunting of the growth of the mammary gland.

In males, during adolescence a small node appears beneath the nipple. This is called the "puberty node." This node may be sensitive and usually has completely disappeared by the eighteenth year. Androgenic hormone effects are held responsible for this node appearing in males.

During the menstrual cycle, there are two changes which occur. The proliferative stage occurs at around the time of ovulation, and is characterized by an increase in the size of the ducts and growth of the lobules, with the appearance of secretory cells in the lobules. The breasts are larger, more tense and firm, and may be tender. The hormones from the corpus luteum are evidently responsible for the development of the secreting lobules of the mammary gland.

The regressive stage starts at the onset of menstruation and lasts for seven or eight days. This stage is characterized by a decrease in the lobular epithelium and collapse of the lobules. The breast is softer and somewhat smaller. This regressive change takes place due to the estrogen effect.

A definite ratio of estrogen and luteal hormones is necessary to maintain normal lobular structure in cyclic women.

Enlargement of the breasts is noticeable five to six weeks after the onset of pregnancy. Increase in size is most rapid from this time to

midpregnancy. The nipple enlarges and the epidermis becomes thickened; also, the areola increases in size and becomes darker.

In the first trimester there is epithelial proliferation in the tubules and extension of tubules into adjacent connective tissue. In the mid-trimester lobules enlarge and secreting cells proliferate. In the third trimester the lobules enlarge, as do the ducts, and the surrounding connective tissue is compressed and becomes more vascular. During pregnancy there is an increase in both estrogen and corpus luteum because the placenta, during pregnancy, puts out both of these hormones. Thus the rapid development in pregnancy.

Colostrum may be expressed from the nipples after midpregnancy; however, true lactation does not occur until three or four days after childbirth. Following delivery and before the appearance of milk, the breasts become increasingly tense and painful.

During lactation the lobules and their efferent ducts serve two functions: the secretion and the storage of milk. The lobules are lined with a single layer of secreting cells. The lobules are distended and the connective tissue is scarce and very vascular. When lactation is at its height, the secreting lobules comprise from one-fifth to one-third of the breast volume, and the expanded duct system acts as a reservoir.

These changes are brought about by the influence of the anterior pituitary lactogenic hormone on the mammary gland, previously stimulated to full lobular development during pregnancy by estrogenic and luteal hormones. The withdrawal of the estrogenic and luteal hormones, upon the expulsion of the placenta at childbirth, appears to act as a stimulus to pituitary secretion of lactogenic hormone.<sup>1</sup>

When the lobules and storage ducts are filled with milk, it is only partially available to the nursing infant. There is a distinction between milk secretion and milk ejection. The mechanism by which the milk is made available is described as the letdown reflex or the draught reflex. This reflex is brought about when the baby takes the nipple into his mouth. Nerves of the nipple are stimulated and afferent nerve impulses are sent to the posterior pituitary which delivers pitocin (oxytocin) into the blood stream. This oxytocic principle goes through

the blood stream to the breast tissue where it acts upon the smooth muscle or contractile cells of the secreting lobules and the storage ducts, and the milk is forced into the areolar lacteal sinuses and made available to the nursing infant.<sup>2</sup>

Other hormones are involved in the development and activity of the breast. It is believed the mammogenic hormone produced by the anterior pituitary has to do with adolescent growth as well as the development of the breasts during pregnancy. Adrenal cortex hormones are believed by some to have a direct relationship to the production of milk. It has already been mentioned that the adrenals may have a part to play in the embryological development of the breasts. The effect of thyroid is thought to be indirect by its action on general metabolism. Naturally the gonadotrophic hormones of the anterior pituitary play an important part by influencing the production of estrogen and corpus luteum.

It is believed that lactation can fail in any stage of development. The long chain of events that take place due to hormone activity can be upset at any period by a disbalance or failure of hormone activity.<sup>3</sup> The disbalance between estrogen and corpus luteum during the menstrual cycle is often a reason for improper development of lobules, and later failure in lactation. Failure may also occur when there is an inadequate supply of lactogenic hormone.

Probably the most common time for failure of lactation is on the third or fourth day postpartum. At this time, due to the influence of the lactogenic hormone, the breasts are engorged with milk. In order for the milk to be made available to the infant, the letdown or draught reflex must take place. As mentioned before, the afferent part of the reflex is due to nerve impulses and the efferent part is due to the effect of the oxytocic principle of the posterior pituitary. Sucking itself is the primary stimulus, but the reflex is very sensitive to psychogenic interferences. The factors that inhibit the reflex are: fear, anxiety, anger, pain, worry, distraction, and the like. When these inhibiting factors cause the reflex to fail, a vicious cycle is set up. It leads to more engorgement, and we have a gland secreting against obstruction, which soon produces involution. When the baby sucks for over two minutes without getting milk,

erosive or petechial lesions appear on the nipple and the nipple is wet, watery and swollen instead of the dry, parched, healthy nipple seen when the flow is free. This leads to cracked nipples.

Pleasant stimuli, quiet familiar surroundings, and freedom from worry all enhance the working of the letdown reflex, and the milk lets down with ease into the areolar sinuses. The nursing child draws the nipple far back into his mouth and his mandible squeezes down on the lacteal sinuses of the areola and there is an easy flow of milk.

Subjective symptoms felt by the nursing mother when the letdown reflex occurs are:

1. Pain in the lower abdomen (oxytocin causing uterine contractions).
2. Dripping of opposite breast while the baby is nursing.
3. Dripping of breasts at sight or expectation of the baby.
4. Cessation of nipple pain after the baby has sucked for a few seconds (negative painful pressure relieved when the vacuum has filled with milk).<sup>4</sup>

In applying the knowledge of the letdown reflex to feeding, we must think of mothers who are: nervous about feeding their babies, upset by strange hospital surroundings, embarrassed by having to expose their breasts to strangers, and uncomfortable with engorged breasts. The baby is brought in on a rigid schedule and may be too sleepy or worn out from crying to start the initial stimulus by nursing vigorously. The rules for feeding in a hospital are designed in such a way as to ignore the letdown reflex, and do not take care of either the needs of the baby or the needs of the breast.<sup>5</sup> Fortunately, mothers are going home from the hospital earlier than a few years ago, and when they get their babies home, a good many of them put their babies on a self-demand schedule. This factor alone is doing a lot to increase the percentage of breast-fed babies. The rooming-in procedure, as practiced in some hospitals, has done much to make breast feeding more practical.

Inhibition to the letdown reflex can be overcome by the injection of .3 cc. of pitocin, one or two minutes before the baby is put on the



breast. I have instituted this measure on several occasions with success.

In dairy farming the letdown reflex has long been recognized and accepted. The cow must not be frightened or disturbed at milking time. She yields more to her accustomed milker than to a stranger. She may hold her milk up entirely. Cows get conditioned to the banging of milk pails and other preparations for milking. Unfamiliar sights and sounds are avoided at milking time.

Each time a fertilized ovum is implanted in the uterus, a fresh impulse is given to the system of ductless glands controlling lactation. This impulse normally continues to the end of lactation, when the baby can live separately from the mother, and eat adult food.

In reviewing the endocrine physiology of the breast, we come to realize that the ductless glands play an important part in the production of milk.

In managing the career of a mother who wishes to nurse her baby, we must apply our knowledge of these mechanisms if we are going to help her feed her baby successfully on the breast.

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## FLASHLIGHT IN THE RECTUM

M. O. SCAMAHORN, M.D.

*Pittsboro*

**F**REQUENT observations have been made in the literature of various foreign objects in the rectum. These are known to vary greatly in size, type and position in the rectum. Usually when these occur in apparently normal individuals the embarrassment makes the person hesitant to seek medical attention and therefore increases the recovery problem.

The unusual occurrence of a regular size flashlight as a foreign body in the rectum is presented in the following case.

#### CASE REPORT

In June of 1951 a white, unmarried, twenty-seven year old, male, World War II veteran came in the office stating that he had "lost" a flashlight in his rectum. The flashlight had been used in his rectum as a means of sexual stimulation. Later questioning brought out that this had been his habit for some twelve years. During this particular instance the flashlight had passed into his rectum and he had made many

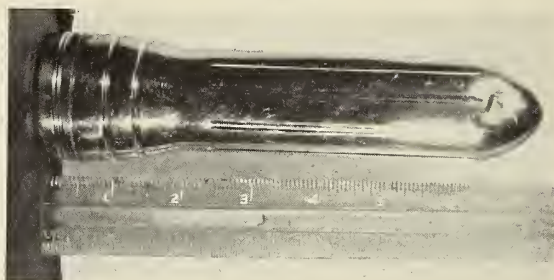
Figure 1.



attempts to remove it. His only comment, other than the one on the flashlight being in his rectum, was that he felt as if his bowels had to move. Digital examination revealed an easily dilatable sphincter, but no foreign object. The patient still insisted that there was a flashlight, "not a pen-light," in his rectum.

An x-ray flat plate of the abdomen (Fig. 1) revealed the flashlight in the rectosigmoid bowel lying with the lens toward the sphincter. The patient was hospitalized and taken to surgery at once. An ether anesthetic was given and the sphincter was dilated to a diameter of four fingers but the object could not be reached. A sound was passed to a distance of approximately twenty-two centimeters, where it touched the flashlight. By deep abdominal palpation this mass could be felt in the left lower quadrant parallel to the inguinal canal. Repeated efforts of pressure on the mass forced it downward to

Figure 2.



a point at the sacral promontory where the rectal hand could touch the mass. Then with posterior pressure, as well as downward abdominal pressure, the flashlight was delivered into the bowel along the sacral hollow. The length of the flashlight case and the curve of the bowel made this particular delivery difficult. Once the flashlight came into the rectal ampulla it was delivered with relative ease. The elapsed surgical time was thirty-seven minutes. The specimen was a regular, full size, two cell (RAY-O-VAC) flashlight (Fig. 2), with a broken lens in place, but devoid of a reflector or bulb.

Postoperatively the patient received ice packs to the perineum and took a regular diet. He refused all medication for pain, soreness or sleep. His hospital stay was uneventful and he had a normal bowel movement at twelve hours. He was released in forty hours and went to work on a factory maintenance crew at seventy-two hours. Office checkups reveal no complications.

#### COMMENT AND SUMMARY

An unusual report is presented of a flashlight successfully removed without complication from the rectosigmoid bowel. One should be aware always that the rectum can be a depository for various foreign objects which present difficult recovery problems.



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## CONGRATULATIONS, DOCTOR YODER!

**D**R. A. C. YODER, of Goshen, received high honors for himself, and also brought honor to the medical profession of Indiana, when he was selected as Family Physician of the Year.

Doctor Yoder was chosen as the Indiana General Practitioner of the Year during the state association's annual session in October. As such he became Indiana's nominee for the national honor. This was accorded him by vote of the A.M.A. House of Delegates in Los Angeles during the interim session.

During the ensuing twelve months Doctor Yoder will represent the general practitioners of the country at many different functions. He will also be representing Indiana medicine.

All Hoosier physicians will join in congratulating Doctor Yoder, and we may all take pride in his sterling accomplishments in the general practice of medicine.

## A.M.A. OFFICE PLAQUE

**E**XPERIENCE of grievance committees has shown that almost all the difficulties that arise between doctors and their patients are due to misunderstandings, either concerning fees or services.

A great majority of these difficulties are, therefore, preventable. They may be prevented by free discussion between the doctor and the patient prior to the time of service.

Many patients hesitate to bring up the subject of fees, but are, nevertheless, anxious to be informed. Doctors, also, may hesitate to volunteer information, on the grounds that such a policy might create an impression of commercialism.

As a matter of fact, there is no reason why patients or their relatives should not seek such information. Most doctors welcome the opportunity, and wish that more people would inquire about fees.

Some means is needed whereby exchange of such information is encouraged. This may be done without the physician making a direct approach to the subject. The A.M.A. is willing to part (at less than cost) with a handsome office plaque which is designed to aid in this public relations problem. Further details are on page 84.



## AID TO MEDICAL SCHOOLS

PRIVATE support of medical education will do more than aid medical schools. It is an insurance policy against one of the means of socializing medicine.

Success of the drive will protect medical schools from the threat of federal domination, since the only alternative to private support is federal subsidy.

The Supreme Court of the United States has ruled that any activity which an organization supports financially it may also direct.

Federal subsidy of medical education will mean the end of medical freedom. Now is the time to adopt measures which will guarantee the continuance of medical freedom in education and practice.

Federal subsidy is one of the wedges which would open the entire profession to socialistic domination. Should federal subsidies be granted there would be no more defense against socialism in education than there is a defense against a home run after the ball is on its way over the fence.

If the cost to each doctor was several times the \$100.00 per year which is sought, it would still be a bargain. It enables each one of us to repay the part of the cost of our own education which was given us by others. It will enable all of us to preserve the system of medical education, which as a part of American medical practice is the best in the world.

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## ANOTHER COMPLICATION OF PREMATURITY

MARY L. NEWMAN, M.D., in an address before the Illinois Obstetrical and Gynecological Society, in August 1951, spoke of a disease first described in 1941 by Terry which is an ophthalmological condition, yet of utmost interest to obstetricians, since in their hands lies the best means, to date, of coping with it,—namely, prevention of premature labor; although, of course, the ophthalmologist is part of the team:

In 1948 Dunham estimated that approximately 150,000 premature infants are born in this country each year. Of these around 4 percent or 6,000 weigh less than 1,000 grams at birth and only 15 percent, or 900, may be expected to survive. Approximately 7 percent, or 10,500 premature babies weigh 1,000 to 1,500 grams and of these 60 percent, or 6,300, may be expected to survive. If, as has been anticipated, 10 percent of these will develop retrolental fibroplasia, we may anticipate more than 700 new cases each year. For it is this group that develop the high incidence of retrolental fibroplasia—this group whose stay in utero we must endeavor to prolong if we hope, not only to reduce the premature mortality rate, but also to lower the incidence of retrolental fibroplasia.

In many cases, the mother first discovers the condition by noticing a hazy or peculiar appearance of the pupil when light falls at a certain angle.

... the disease produces extensive destructive lesions in the eye which almost completely disrupt the normal structures. It is encountered most frequently in small prematures, usually affects both eyes, and causes blindness.

Dr. Newman's paper, as published in *The Illinois Medical Journal*, October, 1951, contains the following conclusion:

In conclusion, may I say that retrolental fibroplasia is a disease of small premature infants which is believed to be either vascular or metabolic in origin with a probable congenital factor. It does not first manifest itself until the infant is approximately three or more weeks old. The disease was first described just 10 years ago and is increasing at an alarming rate. This increase parallels the increased salvage of very small prematures. At the present rate of increase, authorities estimate that retrolental fibroplasia will soon be one of the chief causes of blindness in our schools for the visually handicapped. There is no known established therapy. However, it is thought that there may be some relationship between the administering of water miscible vitamins and iron. Vitamin E, in the form of d-1 alpha tocopheryl acetate is being used prophylactically with ambiguous results. ACTH is being used therapeutically with quite promising results. The main problem is one of prevention. This problem is primarily the obstetrician's, for by prolonging the infant's stay in utero, we may anticipate a concomitant increase in birth weight. Coincident with the reduction of the birth of very small prematures, there should be not only a reduction in premature mortality but also a reduction in the incidence of retrolental fibroplasia.





## President's Page



THE HOUSE of Delegates of the American Medical Association at its interim session in Los Angeles selected Dr. A. C. Yoder of Goshen as the General Practitioner of the year. By the time you receive this edition of The Journal the story will not be new; however, this honor which has come to Doctor Yoder and the State Medical Association of Indiana can very well be emphasized in our own publication.

We had the privilege of serving on a reference committee with Doctor Yoder at the annual convention in 1949. His knowledge of conditions existing at that time and the profound interest which he manifested in medical problems were convincing proof that the House of Delegates of our state association made no mistake in its selection of the General Practitioner of the year for Indiana.

Doctor Yoder has truly been a good, competent family doctor. He has been a regular attendant at postgraduate instructional courses and has kept abreast of the times in new methods of diagnosis and treatment of diseases.

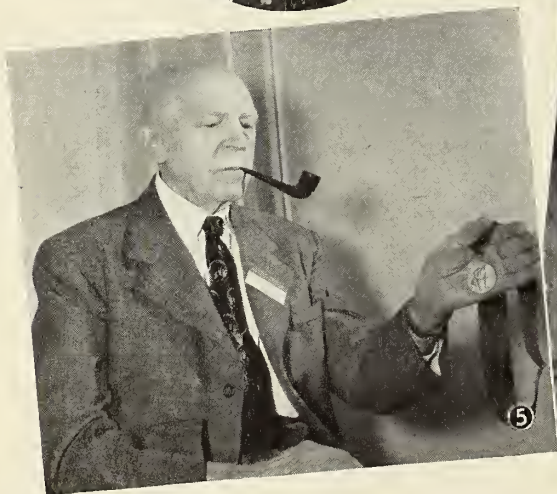
He has been active in the affairs of his county, district and state medical societies, having served as president of his county society, and for thirty-five years as a delegate to the House of Delegates of the state association.

In this troubled world we need more Doctor Yoders and fewer of the type which would attempt to destroy harmony by pitting one group against another, under whose veneer can be visualized the ambition for personal power and aggrandizement of the Hitler-Mussolini element.

So, congratulations, Doctor Yoder! We salute you! May your wisdom and service be a stimulus and a guide to all who wish to endorse the free enterprise of the practice of medicine.

*William Wright*

FROM GOSHEN, INDIANA, TO THE NATION'S FAMILY DOCTOR OF THE YEAR



Here is a pictorial review of the busy life of Indiana's G.P. of the Year after being named AMA's Family Doctor of the Year at Los Angeles, December 4, 1951. Dr. Albert C. Yoder, of Goshen, and Mrs. Yoder arrived in Los Angeles by plane to receive the honor bestowed upon him by the Delegates of the AMA.

1. Dr. and Mrs. Yoder boarding a plane at the Chicago airport, 11:30 Tuesday night, December 4, for their first plane ride. They arrived in Los Angeles at 4:30 a.m., and went immediately to the Biltmore Hotel. Dr. Yoder's comment, upon being notified of his selection, was "This is more sudden than when my wife proposed to me."

2. Congratulatory telegrams from friends in Indiana and elsewhere poured into Dr. Yoder's room at the Biltmore. He and his wife read them in peace and quiet during a brief lull in his busy schedule.

3. First date on Dr. Yoder's schedule was a radio broadcast with three previous winners of the "Family Doctor of the Year" medal. Pictured left to right are: Dr. Denn Sherwood Luce, Canton, Mass., winner in 1950; Dr. W. L. "Buck" Pressly, Due West, S. Carolina, 1948 winner; Dr. Andy Hall, Mount Vernon, Ill., winner in 1949, and Dr. Yoder.

4. Dr. Yoder was whisked from a radio broadcast to face a battery of newsreel photographers. With cameras trained on him, he thanks Dr. John W. Cline, President of the AMA, who has just congratulated him on the fine work he has done as a general practitioner and on his election as the "Family Doctor" award winner.

5. Allowed to relax at last, Dr. Yoder takes a good look at the solid gold medal he received. The medal has a figure of a family doctor and is inscribed with his name and the year he received it.

6. Now officially the nation's "Family Doctor of the Year," Dr. Yoder thanks Dr. Cline and members of the House of Delegates for the honor bestowed upon him. Dr. Cline presented the award to Dr. Yoder in a formal ceremony before the House of Delegates on Thursday morning, December 6.



# Medical Panorama *by the* ASSOCIATE EDITOR

## THE PRACTICING PHYSICIAN AS STATISTICIAN

Medical statistics, often labeled "dry" by those who consider themselves "practical," are just as important to the general practitioner, or to the practicing specialist, as they are to the most abstract researcher. "Figures don't lie, but liars will figure" is still a good axiom, and while we expect no real "liars" as medical authors, it is possible one might find earnest men of science who would never fabricate a deliberate untruth but whose interpretation of statistics may be influenced by a "pet theory."

Many modern papers on clinical subjects employ statistical records, and to assist him in judgment of these the doctor-reader should have some means of discrimination. An editorial in *The Journal of the Medical Society of New Jersey*, August, 1951, cites some "common-sense yardsticks" which can be used for this purpose:

Among the pitfalls into which medical authors may fall are inadequate controls, insufficient sampling, and erroneously weighted statistics. Other errors include those of significance and probability.

In papers presenting comparisons between series of cases, certain criteria should be met. The series should be comparable in size, homogeneity, and degree of disease process. If normal controls are involved, they must be truly normal. This may become a real problem in dealing with a disease such as arteriosclerosis. Here it is extremely difficult to determine that a "normal" subject is completely free of arteriosclerosis. There is simply no readily available test for the detection of latent or subclinical arteriosclerosis.

Errors of sampling are seen in too many medical articles. This is especially common in papers dealing with therapeutic results. A recently published article recommended a particular therapeutic regimen for hypertension, based on seven cases in which there was minimal lowering of the blood pressure after four weeks' observation. In such a protean disease as hypertension, this sample was obviously far too small, the changes in blood pressure too slight to be of significance, and the period of observation much too brief. On the other hand, in an almost universally fatal condition, (like tuberculosis meningitis) even a few cases showing good results with a given treatment may be an adequate sample, and reported results may be genuinely significant. The reader should have a basic knowledge of the subject under discussion, an idea as to the natural course of the disease, and information concerning other forms of therapy before he can accept the conclusions as valid.

Unfair weighting of statistics is another source of misleading information. In many papers, cases are excluded from the final statistical results when they properly should be included. This error is especially common in deriving mortality figures.

It is obvious that the practitioner uses statistics many times daily in his routine duties, whether he realizes it or not,—for instance, in all judgments

as to probability (and therefore in every prognosis), in many diagnoses, and sometimes in choice of therapy. The experience accumulated over long years in practice is itself a kind of statistical mosaic integral to the structure called clinical judgment.

## ARE DOCTORS REALLY SCARCE?— A NEW "ANGLE"

We have heard and read much debate on the subject of the adequacy of the supply of physicians in this country. *The Connecticut State Medical Journal* for November, 1951, carries a note on certain statistics resulting in a different angle of approach to this problem, and furthermore, one which seems to us less apt to be biased than some other methods. But read for yourself:

The income of physicians in the United States, between 1929 and 1949, is the subject of a recent survey sponsored jointly by the Office of Business Economics of the Department of Commerce and the Bureau of Medical Economic Research of the American Medical Association.

\* \* \* \*

The average net income of all physicians since 1929 more than doubled, but in the same period all wage earners equalled this increase.

\* \* \* \*

The income of Connecticut physicians is of especial interest. This survey shows that doctors in this State, which ranks seventh in general per capita income, earn less than those in the majority of States throughout the country.

\* \* \* \*

The question that arises, and there is no obvious answer to it, is why physicians in this section of the country earn less than those in the middlewestern, southwestern, and farwestern parts of the United States. There is no ready solution to the differential between the average earnings by physicians in Connecticut and other sections of the country. It may be surmised that it is due to the difference in the number of physicians in relation to population. Dickinson's survey points out that a nationwide shortage of physicians, which has been alleged by several writers, would almost certainly have resulted in a greater increase in physicians' income. It is fair to assume on the basis of the figures available that there is no general economic evidence of a national shortage of physicians.

Lest it be argued that the survey was "unfair," the information set forth

... is based on returns from 55,000 doctors out of a possible 125,000 and has been termed as the "best and broadest mail questionnaire income survey ever taken of any profession."

## OLIVER WENDELL HOLMES, M.D.

1809-1894

EDGAR F. KISER, M.D.

INDIANAPOLIS

UPON a wall of my consultation room there hangs a large panel bearing the portraits of a number of American physicians and surgeons, some dating back to the colonial period and some moderns, all of whom have deserved recognition by reason of outstanding contributions to the practice of our profession.

Among these pictures there is a portrait of Oliver Wendell Holmes. Scarcely a day passes without some patient inquiring "Why is Holmes in that group?" Very few of the laity know that he was a physician and a brilliant one, but what is more surprising is that relatively few doctors know that he was one of us. Hence this essay.

Quite a few graduates in medicine have forsaken Aesculapius for a literary career. John Keats and Oliver Goldsmith had earned the degree of M.D., but to the best of my knowledge never practiced. Conan Doyle was a very successful physician long before he turned author. S. Weir Mitchell was a renowned practitioner who used writing as an avocation with tremendous success. Currently A. J. Cronin and W. Somerset Maugham are much better known by their books than by their prescriptions.

Oliver Wendell Holmes entered college intending to study law, as did Longfellow and Washington Irving, but in his twentieth year he exchanged his Blackstone for Gray. "The temple of the law seems very cold and cheerless about the threshold," was his comment.

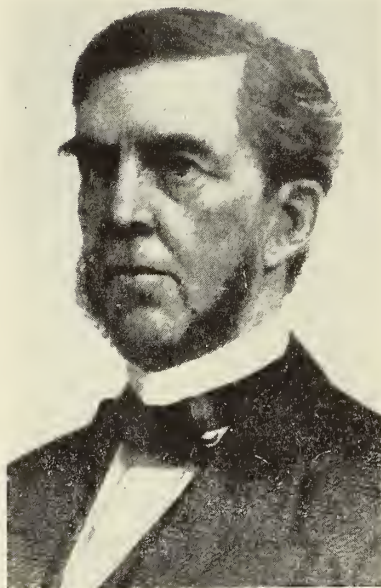
Holmes was blessed with an excellent heritage—an upbringing that eventually justified his place as a member of the "Brahmin Caste of New England." His father, the Rev. Abiel Holmes, was a "temperate Calvinist," a Yale graduate, a man of letters, who saw to it that his son received every advantage that ultimately made of him a real scholar. At fifteen years of age Wendell was sent to Andover to prepare for Harvard, and on his sixteenth birthday qualified for entrance to that college. While not regarded as an exceptionally brilliant student, he made Phi Beta Kappa.

Early in his college career he showed a remarkable aptitude for both prose and poetry and was made class poet. Throughout the years in Harvard he wrote many of his well-known poems, most of which were published anonymously in college papers and magazines. He earned his A.B. at twenty and the following year entered Harvard Medical School. As was customary, his introduction to medical education was in the dissecting room. One of his biographers says "There were young men of different ambitions crowded about a table with a skeleton hanging over and bones lying about, but this particular neophyte was somewhat shocked at first and disposed to moralize on immortality and not immediately eager to learn the mysteries of osteology." However, he persevered and, under the tutelage of his preceptor, Dr. Winslow Lewis, mastered the intricacies of Wistar's "System of Anatomy," the earliest treatise on the subject published in this country. (1811.)

The Harvard curriculum encompassed only five subjects: Theory and Practice of Medicine; Anatomy and Surgery; Obstetrics; Medical Jurisprudence and Chemistry; *Materia Medica*. Physiology was not

taught except as a by-product of anatomy and there was no microscope in the college. A bit of Latin and elementary physics were required for college entrance and two terms of four months each for graduation. The most important medical instruction came from intimate association with a preceptor and after an apprenticeship of three years the student was required to submit a medical thesis and take a perfunctory oral examination before he was permitted to practice.

Doctor Holmes was singularly fortunate in that he did not have to apprentice himself to a practicing physician. Shortly before he matriculated in the Medical Department of Harvard, a group of outstanding Boston physicians, Walter Channing, James Jackson, Sr., Winslow Lewis, George Otis and John Ware, organized a course of training far superior to that acquired by association



Oliver Wendell Holmes, M.D.



with a busy doctor. Holmes availed himself of the opportunity afforded by this study group and that, coupled with the Harvard teaching, provided the best medical education available in this country. Students who satisfied the requirements of the study group were exempt from apprenticeship.

For three years after graduation Holmes was intimately associated with James Jackson, Sr., and it was from him that he received most of his clinical training. Jackson was outstanding in Boston. He was the first physician to the Massachusetts General Hospital (1810) and wrote one of the earliest and best textbooks on practice (1825). Holmes idolized him and learned from him that "The first tenet of the physician is his insistence that he does not so much cure his patients, as care for them." His "Letters to a Young Physician" has long been regarded as a medical classic (1855).

Holmes put in long hours in the dispensary and in the wards of the hospital. He was still writing prose and poetry but not with the enthusiasm that he showed while a student. His heart was in his medicine. To a close friend who wrote to ask if he would be a welcome visitor over a week end he replied: "I cannot promise you much, but I will give you a good dinner, and a glass of wine somewhere or other, and some good cigars if you smoke, and say 'come in' when you knock at the door of my attic. But I must go to the hospital and to the eye infirmary, and I must dissect, if you bring the Governor and Senate with you."

At the end of his second year in Harvard he decided to postpone taking his degree and go to Europe. Dr. Samuel Jackson, Jr., Mason Warren and other friends had gone to France for study and he craved both the opportunity of studying under some of the outstanding leaders in the French hospitals and also the prestige that in the eighteen hundreds came with study abroad. In March 1833 he sailed to France. On the night of his departure, Doctor Jackson, Sr., wrote to his son: "Many of my cases have been interesting and instructive—to me at least. Students do not seem to me to be eager to acquire the knowledge which cases afford, as I could wish. Holmes knows more of my cases this winter than anyone—he spent three or four months in the hospital as apothecary. If you see him, he can tell you much that is interesting. Do not mind his apparent frivolity and you will soon find that he is intelligent and well informed. He has the true zeal."

Immediately upon his arrival in Paris, Holmes arranged to make ward rounds with the famed Louis in the hospital LaPitié. Pierre Charles Alexandre Louis was perhaps the outstanding teacher of medicine on the Continent in the 19th century. Osler says of him that "through his American pupils, Holmes, Gerhard, the Jacksons, the Shattucks and others, he exerted a powerful influence upon the advances of medical science in the Eastern United States." Eleanor M. Tilton, in her recently

published biography of Holmes, recites an interesting anecdote: Holmes had scarcely arrived in Paris when the earnest Henry Ingersol Bowditch (another American student) began singing the French pathologist's praises so loudly that Holmes was incredulous. When Bowditch implied that Louis was a better teacher than Doctor Jackson, Holmes was quick to defend the man he so much admired. Bowditch, writing home, reported the encounter. "We had a fight (as he called it) for an hour, and the next day I heard of his having said that either Louis was the greatest man that ever lived in medicine or that I was crazy." Holmes had quickly discovered that Bowditch was not so crazy as he had seemed. It took him only a short time to appreciate Louis' worth. After a very few months he wrote: "I have learned at least three principles since I have been in Paris—not to take authority when I can have facts; not to guess when I can know; not to think a man must take physic because he is sick."

Holmes, of course, attended the clinics and autopsies of other famous teachers, among them Chamel, Andral, Roux and Velpeau. He was bored by the physiologist Richerand, "a celebrated old gentleman in his day, now somewhat used up." Many years later he regretted his error in not having taken physiology seriously.

He remained in Europe until November 1835, and of course spent some time in England, Germany and Italy, but it was Paris, and particularly his beloved Louis, that laid the foundation of his medical accomplishment. As before stated he had not taken his medical degree before going abroad. The requirements for obtaining a medical degree in the early eighteen hundreds were a written thesis on some medical or surgical problem and an oral examination by a member of the faculty. Holmes satisfied both of these requirements shortly after his return from abroad and was granted his diploma in February 1836. In May of the same year he was accepted by the Massachusetts Medical Society and opened an office as a general practitioner. It is the consensus of his various biographers that his heart was never in practicing medicine but rather that he had his eye on a professorship. However, he accepted the position of visiting physician to the Boston Dispensary but found it poorly supervised and lacking in proper facilities. He abhorred the fact that the patient with a pull had more immediate and better attention than did John Doe. Though a very young physician, he sensed that what today we call social service was often more important than a tonic or a pill. A quarter of a century after his association with the dispensary (1860), in an address to the state medical association he said:

"Medication without insuring favorable hygienic condition is like amputation without ligatures. I had a chance to learn this well of old, when physician to the Broad Street district of the Boston Dispensary. There, there was no help for the utter want of wholesome conditions, and

if anybody got well under my care, it must have been in virtue of the rough-and-tumble constitution which emerges from the struggle for life in the street gutters, rather than by the aid of my prescriptions."

In 1838 Holmes joined with three other Boston physicians, Jacob Bigelow, Edward Reynolds and David Storer, in the formation of the Tremont Medical School. It was much the same type of school as the one in which he had studied in lieu of his apprenticeship. It had a loose connection with Massachusetts General Hospital, the Eye and Ear Infirmary and the Lying-In Hospital, and was withal a very good teaching institution. Holmes taught physiology and pathology, quizzed in anatomy, and taught the use of the stethoscope. He was among the first in America to teach microscopy.

In the same year he was appointed to the Professorship of Anatomy at Dartmouth College. He was required to spend only fourteen weeks at the school annually and received four hundred dollars as his stipend. He not only taught anatomy but lectured on physiology, surgical anatomy, and chemistry, and is said to have remarked that he did not occupy a "chair" but rather a "settee" while in Hanover. He remained with the school only two years.

On June 15, 1840, Doctor Holmes was married to Amelia Jackson, a niece of the Dr. James Jackson whom he had always so greatly admired. In March of 1841 their first child was born, a son, Oliver Wendell, Jr., destined to become a Justice of the Supreme Court of the United States.

As previously remarked, he had not acquired a lucrative practice and supplemented his income by the lecture platform and contributions to magazines. In April, 1847, he was elected to the position of Professor of Anatomy and Physiology of the Harvard Medical College and remained in that capacity until November, 1882.

In the middle fifties of the nineteenth century the professors in medical schools received no salary directly from the school. Instead each student bought a "card of admission" from each of the instructors. Holmes' classes were always well attended and his remuneration was quite considerable. Parenthetically, the "cards of admission" are eagerly sought by medical historians as memorabilia.

During all of his sojourn abroad Doctor Holmes did not write so much as a single stanza, but he had scarcely set foot on American soil until numerous magazines urged that he again "take up his pen." The pressure was great and authorship was in his blood. Within a month after his return he published two poems, "An Evening Thought" and "La Grisette," in a magazine edited by an intimate friend. Neither of these was signed. However, an old schoolmate identified them and wrote a congratulatory note. Holmes was gratified

but in his reply to the friend said that what he wished to do was to engage in "a regular occupation, one which can support one and give one a hold on the community in which I live, and which my love of observation and the habits which I have formed for the last few years have rendered me the most delightful of employments."

In the eighteen thirties, medical journals were quite scarce in this country. Even the eastern states had but a very few and medical knowledge was disseminated in large part by word of mouth and occasional medical meetings. In order to stimulate more doctors to take part in the activities of the organization, the Massachusetts Medical Society offered medals or cash prizes for dissertations on prescribed subjects. The officers of the society selected what they considered the most valuable papers, and not only awarded prizes, but published them in book form.

In 1834 the medical society appointed a committee to determine "To What Extent, and In What Places Has Intermittent Fever Been Indigenous In New England." The committee sent printed questionnaires to a large number of physicians throughout the New England states but received only two replies. Discouraged, they dropped the project. Holmes, however, felt the need of such a survey and undertook what the society's committee discarded. He wrote personal letters to the more important physicians in the various communities, in place of the printed questionnaire. Even then the response was scant and though he was at times discouraged to the point of discarding the venture he perused all available newspapers, historical documents, and even extant printed sermons, and finally published a satisfactory dissertation, so satisfactory, indeed, that it drew a prize from the society.

In 1836 the medical society again offered a prize for the best paper on "How Far Are the External Means of Exploring the Condition of the Internal Organs To Be Considered Useful and Important In Medical Practice?" It is quite obvious that such a paper was apropos, as it was really *prima facie* evidence that percussion and auscultation were not in common use in the states even though the techniques of Auenbrugger and Laennec were available to any doctor who cared to adopt them.

(Auenbrugger's volume on percussion was issued in 1761, but was almost entirely ignored by the medical profession. It was resurrected by Corvisart in 1808. Laennec invented the stethoscope in 1815 and published his epoch-making treatise on the chest in French in 1819. The first English translation by John Forbes appeared in 1821.)

Holmes, of course, submitted a paper and again won the prize. It was published in book form with two other papers of quite mediocre quality and the doctor seems to have been elated over his conquest as he wrote to a friend: "The Boylston prize was almost unanimously awarded to my



dissertation. The committee, however, have determined to pay for and publish two others . . . by Dr. Haxall and Dr. Bell. This is what they have never done before, and it is somewhat pleasant to have cut out a fifty-dollar prize under the guns of two old blazers, who have each of them swamped their competitors in preceding trials."

Doctor Bell, in a footnote in his paper, gives a glimpse of the diagnostic procedures ordinarily used in 1836. "I have no means of knowing to what extent the practice of exploration of the chest has been adopted in the United States. In the larger towns and cities, I am aware, it has been considerably and successfully cultivated, but in the interior of New England, at least by the great body of practitioners, it has been neglected. It has unfortunately been deemed, and this I doubt not from the Frenchified aspect of the works in which it has been communicated, as a subject too abstruse and difficult for the common class of medical men. As a single individual, laboring under all the disadvantages which have been brought forward in disparagement of these methods, except the favorable circumstance of having been faithfully indoctrinated in its principles by a private pupil of the illustrious inventor, I would accord my unqualified opinion of its high value to the ordinary physician, nor would I after more than a dozen years' experience, relinquish its aids, so soon as any other single mean of pulmonary diagnosis."

Holmes, on the other hand, wrote, "Not only are the classical works of Louis and Andral filled with the applications of the art of direct exploration, but the stethoscope and the pleximeter are to be found in the hands of every Parisian student, and what is still more, of grey headed professors who were no longer young when Laennec published his discoveries; as a means of investigation which it would be ignorance not to understand, and unpardonable carelessness to neglect. If we look at the English physicians, whom we are accustomed to believe less ardent for curious innovations, the pages of the London Cyclopaedia of Practical Medicine, filled by the most distinguished practitioners in the country, bear witness to the immense value of the new resources which have been offered to science. The names of Clark, and Forbes, and Hope, may fairly be weighed against that of the flippant scribbler of a page in the Athenaeum, who, in 1836, in speaking of the stethoscope, tells us that 'the toy is a new toy.' If Harvey, among all his opponents, deigned only to answer Riolaenus, and that on account of his 'rank, fame, and learning,' the inventor of the 'new toy,' were he still living, would have even fewer controversies than the discoverer of the circulation. It would be easy to multiply names, not only in England but in our country; but we are unwilling to carry this invidious argument farther, especially as it is fully understood by all who keep pace with the current medical literature."

Shortly after the publication of the paper on diagnosis, Holmes wrote another on neuralgia and once more took the prize. *The Boston Medical and Surgical Journal* remarked that "It is almost useless to contend with him in an enterprize of this kind."

In 1810, Samuel Christian Friedrich Hahnemann, a German, as the name would imply, published his book on homeopathy. Holmes had become well acquainted with the fallacy of "Similia similibus curantur" while a student in Europe. Although a therapeutic nihilist,\* he deplored the use of drugs which he felt certain had no curative value and which he knew were every day being used by thousands. At the time he was lecturing to the public on three subjects: "Astrology and Alchemy," "Medical Delusions of the Past," and "Homeopathy." They were so well received that he combined the two latter and published them under the title of "Homeopathy and Its Kindred Delusions." "The Kindred Delusions" were in large measure but a single item, a tirade against a charlatan, Dr. Elisha Perkins of Connecticut, who devised a gadget which he marketed under the name of Perkins Metallic Tractors. The device consisted of nothing more than "two pieces of metal, one apparently iron and the other brass, about three inches long, blunt at one end and pointed at the other." This was to be drawn "over the affected part lightly for about twenty minutes." Ridiculous as it seems, the "tractors" were a panacea for the neurotics of that era, and the country was flooded with them. Asked how to explain why such a ridiculous device became a household necessity, Holmes said, "A man who has paid twenty-five dollars for his whistle is likely to blow it louder and longer than other people." And in a more serious vein he said "Those who know nothing of the natural progress of a malady, of its ordinary duration, of its various modes of terminating, of its liability to accidental complications, of the signs which mark its insignificance or severity, of what is to be expected of it when left to itself, or how much or how little is to be anticipated from remedies, those who know nothing or next to nothing of all these things, and who are in a great state of excitement from benevolence, sympathy, or zeal for a new medical discovery, can hardly be expected to be sound judges of facts which have misled so many sagacious men who have spent their lives in the daily study and observation of them."

Several of Doctor Holmes biographers regard this dissertation on homeopathy one of the most important of all of his medical papers. It was written in an earnest, serious mood, devoid of the frivolous or at times the sarcastic style which he often affected. But a far more important paper, unquestionably his *opus magnum*, was soon to

\* "If the whole *Materia Medica*, as now used, could be sunk to the bottom of the sea, it would be all the better for mankind, and all the worse for the fishes."

follow. On June 28, 1842, Dr. Walter Channing, at a meeting of the Boston Society for Medical Improvement, reported thirteen cases of "fatal puerperal fever." On November 28 he followed with an additional series.

In the interim Dr. John Fisher had reported several cases, and in Philadelphia Dr. Francis Condie addressed the Philadelphia College of Physicians on the subject and suggested that puerperal fever "might be contagious." There were a number of deaths reported among physicians who had been infected by autopsy wounds and finally a Dr. John Jackson, in an address before the Boston Society, suggested "the possibility of physicians communicating it from one patient to another."

Doctor Holmes had long been deeply interested in the subject, and, avid reader that he was, he combed all of the available material at hand, and concluded that puerperal fever was unquestionably contagious; that physicians, midwives and nurses were carrying the contagion from patient to patient. Just three weeks after Doctor Jackson addressed the society, Holmes read before the same organization his ever memorable essay entitled "The Contagiousness of Puerperal Fever." He knew that as early as 1795 Doctor Gordon of Aberdeen had published an essay in which he said "This disease seized such women only as were visited, or delivered by a practitioner, or taken care of by a nurse, who had previously attended patients affected with the disease . . . I have arrived at that certainty in the matter that I can venture to foretell what women will be affected with the disease, upon hearing by what midwife they are to be delivered, or by what nurse they are to be attended, during their lying in, and almost in every instance, my prediction has been verified."

Holmes knew, too, that in 1822 a Doctor Davies reported in the "Medical Repository" his belief in the contagiousness of childbed fever, and that in 1835 Doctor Ramsbotham in a lecture at the London Hospital asserted "that he had known the disease to spread through a particular district, or be confined to the practice of a particular person, almost every patient being attacked with it, while others had not a single case."

Following these early reports, he collected innumerable instances of epidemics to substantiate his premise. His essay was lengthy and he pulled no punches, and invited the invectives which were immediately heaped upon him. Inasmuch as Holmes was not an accoucheur, his most severe critics were naturally the obstetricians, two in particular, Hugh L. Hodge, M.D., Professor of Obstetrics in the University of Philadelphia, and Charles D. Meigs, M.D., Professor of Midwifery in Jefferson Medical College.

The essay was unfortunately published in the *New England Quarterly Journal of Medicine and*

*Surgery*, an ephemeral journal which survived but a year. Its circulation was very small and Holmes had only a few reprints made. In consequence the tremendously important paper reached very few physicians and it was only a two-page abstract published in the *American Journal of the Medical Sciences* in 1846, that brought to the attention of the profession at large the etiology of puerperal sepsis.

The profession was divided as to the accuracy of Holmes' statements, and Hodge and Meigs left no stone unturned to belittle him. Hodge delivered a so-called introductory lecture "On the Non-Contagiousness of Puerperal Fever" to his students; and Meigs reached the physicians by a series of letters "On the Nature, Signs and Treatment of Child-bed Fever" and he indoctrinated his students through the textbooks which he wrote. Of the two men, he was far the more vitriolic.

Holmes accepted the criticism of Hodge and Meigs in the manner that one would expect of a stalwart, born and bred New Englander. He wrote "The teaching of the two professions in the great schools of Philadelphia are sure to be listened to, not only by the profession at large. I am too much in earnest for either humility or vanity, but I do entreat those who hold the key of life and death to listen to me also, for this once. I ask no personal favor; but I beg to be heard in behalf of the women whose lives are at stake, until some stronger voice shall plead for them."

By 1845 or '46 articles in the various journals had veered to the side of Holmes. In 1852 Copeland's Medical Dictionary credited him with his deliberations and incorporated in their article their firm belief in his teaching. Encouraged by the turn of events, he determined to reprint his original paper. In 1855, with the caption "Puerperal Fever as A Private Pestilence," he presented it to the profession with a long prefatory discourse: "I send this essay again to the medical profession without the change of a word or syllable. . . . I appeal from the disparaging language by which the Professor in the Jefferson School of Philadelphia would dispose of my claims to be listened to. I appeal, not to the vote of the Society for Medical Improvement, although this was an unusual evidence of interest in the paper in question, for it was a vote passed among my own townsmen; nor to the opinion of any American, for none know better than the Professors in the great Schools of Philadelphia how cheaply the praise of native contemporary criticism is obtained. I appeal to the recorded opinions of those whom I do not know, and who do not know me, nor care for me, except for the truth that I may have uttered; to Copeland, in his 'Medical Dictionary,' who has spoken of my Essay in phrases to which the pamphlets of American 'scribblers' are seldom used from European authorities; to Ramsbotham, whose compendious eulogy is all that self-love



could ask; to the 'Fifth Annual Report' of the Registrar-General of England, in which the second-hand abstract of my Essay figures largely, and not without favorable comment, in an important appended paper. These testimonies, half forgotten until this circumstance recalled them, are dragged into the light, not in a paroxysm of vanity, but to show that there may be food for thought in the small pamphlet which the Philadelphia Teacher treats so lightly. They were at least unsought for, and would never have been proclaimed but for the sake of securing the privilege of a decent and unprejudiced hearing."

Shortly after this publication the *American Journal of the Medical Sciences* again reviewed and approved it and at the same time the *Journal of the American Medical Association* heartily recommended it to its readers.

Six years after the publication of this latter essay, Ignaz Philipp Semmelweis, of Vienna, published his classic "DIE AETIOLOGIE, DER BEGRIFF UND DIE PROPHYLAXIS DES KIND-BETT FIEBERS" (The Cause, Concept and Prophylaxis of Puerperal Fever) which, of course, substantiated Holmes' teaching.

Careful and painstaking as Holmes was, one of his efforts proved that to err is human. He and one of his close friends, Dr. Jacob Bigelow, undertook the English translation of Marshall Hall's French textbook on "The Principles of the Theory and Practice of Medicine" which had been very popular in France. Unfortunately the translation proved to be a complete failure and was criticized by practically every reviewer. For many years Holmes lost no opportunity to apologize for it.

The number of Holmes medical addresses, essays, papers and dissertations are legion, but he selected just nine to comprise his volume of "Medical Essays":

Homeopathy and Its Kindred Delusions.

The Contagiousness of Puerperal Fever.

Currents and Counter-Currents in Medical Science.

Border Lines of Knowledge in Some Provinces of Medical Science.

Scholastic and Bedside Teaching.

The Medical Profession in Massachusetts.

The Young Practitioner.

Medical Libraries.

Some of My Early Teachers.

Space will not permit a comment on each of them. However, a paragraph in an address delivered before the Massachusetts Medical Society at the Annual Meeting, May 30, 1860 and incorporated in his "Currents and Counter-Currents" will give the reader an idea of his style. It is a "mass" epitaph, a literary gem:

"Our Annual Meeting never fails to teach us at least one lesson. The art whose province it is to heal and to save cannot protect its own ranks from the inroads of disease and the waste of the Destroyer.

"Seventeen of our associates have been taken from us since our last Anniversary. Most of them followed their calling in the villages or towns that lie among the hills or along the inland streams. Only those who have lived the kindly, mutually dependent life of the country, can tell how near the physician who is the main reliance in sickness of all the families throughout a thinly settled region, comes to the hearts of the people among whom he labors, how they value him while living, how they cherish his memory when dead. For these friends of ours who have gone before, there is no more toil; they start from their slumbers no more at the cry of pain; they sally forth no more into the storms; they ride no longer over the lonely roads that knew them so well; their wheels are rusting on their axles or rolling with other burdens; their watchful eyes are closed to all the sorrows they lived to soothe. Not one of these was famous in the great world; some were almost unknown beyond their own immediate circle. But they have left behind them that loving remembrance which is better than fame, and if their epitaphs are chiselled briefly in stone, they are written at full length on living tablets in a thousand homes to which they carried their ever-welcome aid and sympathy."

Our beloved Sir William Osler was a great admirer of Doctor Holmes. In the January issue of the *Montreal Medical Journal*, 1889, he wrote concerning Holmes:

"Literature has often been enriched by those who have deserted medicine for the muses. But to drink deep draughts at Pierian springs unfits, and when the thirst is truly divine should unfit, a man for the worrying rounds of practice. It is shocking to think that had Goldsmith secured the confidence of the old women in Bankside, Southwark, we should probably never have known the Vicar, Olivia, or Tony Lumpkins. Still worse, to think of what we should have lost had Keats passed on from a successful career at Guy's to obtain even a distinguished position as a London Surgeon! Happily, such men soon kick free from the traces in which the average doctor trots to success.

"The most conspicuous modern example of success in both fields is offered by the Autocrat of the Breakfast Table, who for many years occupied the Chair of Anatomy at Harvard, and who as a young man made permanent contributions to practical medicine. In his last book, 'One Hundred Days in Europe,' he mentions having sat next to Mr. Lawson Tait at dinner and he suggests the question, 'Which would give most satisfaction to



a thoroughly humane and unselfish being of cultivated intelligence and lively sense—to have written all the plays which Shakespeare has left for an inheritance to mankind, or to have snatched from the jaws of death scores of suffering women and restored them to a sound and comfortable existence?" I know of no man who could so well make answer to this question as the Autocrat himself. Would he rather go down to posterity as the man who, in this country at least, first roused the profession to a sense of the perils of puerperal fever as an infectious disease—and who thereby has probably saved more lives than Lawson Tait—and whose essay on the subject is a classic in American literature, or would he choose to be remembered as the author of 'The Chambered Nautilus' and 'The Last Leaf'?"

Osler pondered the thought and eventually wrote to Holmes, who replied:

"My dear Sir,—I have rarely been more pleased than by your allusions to an old paper of mine. There was a time certainly in which I would have said that the best page of my record was that in which I had fought my battle for the poor poisoned women. I am reminded of that Essay from time to time, but it was published in a periodical which died after one year's life and therefore escaped the wider notice it would have found if printed in the *American Journal of Medical Sciences*. A lecturer at one of the great London Hospitals

referred to it the other day and coupled it with some fine phrases about myself which made me blush, either with modesty or vanity, I forget which.

"I think I will not answer the question you put me. I think oftenest of the 'Chambered Nautilus,' which is a favourite poem of mine, though I wrote it myself. The Essay only comes up at long intervals, the poem repeats itself in my memory and is very often spoken of by my correspondents in terms of more than ordinary praise. I had a savage pleasure, I confess, in handling these two professors—learned men both of them, skilful experts, but babies as it seemed to me in their capacity of reasoning and arguing. But in writing the poem I was filled with a better feeling, the highest state of mental exaltation and the most crystalline clairvoyance, as it seemed to me, that had ever been granted to me. I mean that lucid vision of one's thought and all forms of expression which will be at once precise and musical which is the poet's special gift, however large or small in amount or value. There is some selfish pleasure to be had out of the poem, perhaps a nobler satisfaction from the life-saving labour. . . ."

This letter to Doctor Osler can mean only one thing, that Holmes, throughout his life, wavered between medicine and manuscript. One thinks of him as having had the mind of a physician, the heart of a poet.

**CONTRIBUTIONS TO MEDICAL EDUCATION FOUNDATION FUND—AS OF DECEMBER 26, 1951**  
(Pledged during and since annual session of ISMA—does not include gifts prior to annual session.)

Name of County	Number of Physicians Contributing	Total Amount Contributed	Name of County	Number of Physicians Contributing	Total Amount Contributed
Adams	1	\$ 25.00	Lawrence	4	185.00
Allen	4	115.00	Madison	2	225.00
Bartholomew-Brown	3	110.00	Marion <sup>1</sup>	50	2,700.00
Benton	1	25.00	Marshall	2	50.00
Boone	2	100.00	Montgomery	3	155.00
Carroll	1	50.00	Morgan	1	50.00
Cass	2	200.00	Owen-Monroe	2	160.00
Clark	2	110.00	Perry	2	30.00
Clay	2	200.00	Pike	1	100.00
Clinton	1	33.00	Porter	2	60.00
Daviess-Martin	2	75.00	Putnam	1	50.00
Dearborn-Ohio	2	200.00	Randolph	2	65.00
DeKalb	1	25.00	Ripley	2	70.00
Delaware-Blackford	7	365.00	Rush	4	150.00
Elkhart	2	50.00	St. Joseph	11	675.00
Fayette-Franklin	3	250.00	Starke	2	60.00
Floyd	2	200.00	Shelby	2	110.00
Fulton	1	10.00	Sullivan	1	15.00
Grant	1	25.00	Tippecanoe	7	210.00
Greene	1	25.00	Tipton	1	100.00
Harrison	1	33.50	Vigo	3	105.00
Hendricks	2	100.00	Vanderburgh	5	575.00
Henry	2	125.00	Wabash	2	51.00
Howard	3	125.00	Warrick	1	50.00
Huntington	1	10.00	Wayne-Union	13	705.00
Jackson	1	50.00	Wells	14	1,000.00
Jasper-Newton	2	50.00	Kosciusko County Society		100.00
Jay	2	70.00	Out-of-State	3	76.00
Jefferson	1	100.00			
Johnson	1	10.00			
Knox	3	160.00			
Lake	15	845.00			
LaGrange	1	5.00			
LaPorte	2	250.00			
			61	219	\$12,008.50

<sup>1</sup> Includes gift of \$100.00 from Academy of General Practice.

<sup>1</sup> Includes gift of \$500.00 from Indianapolis Medical Society.

## REPORT ON 1951 AMA CLINICAL SESSION

A. S. GIORDANO, M.D.\*

SOUTH BEND

THE 1951 Clinical session of the American Medical Association, held in Los Angeles, December 4-7, 1951, turned into an Indiana affair with the election by the House of Delegates of Dr. Albert C. Yoder, Goshen, as the nation's "Family Physician of the Year." Doctor Yoder, who was named Indiana's General Practitioner of the year during the last annual session of the ISMA, was voted the nation's "Family Doctor" of the year by an overwhelming majority of the AMA Delegates.

It is customary for each state to submit the name of the physician selected by its state as the "Doctor of the Year" along with a formal presentation to the AMA. The Board of Trustees of the AMA then selects three candidates and reads their qualifications before the House, which then votes its choice. While Indiana's physicians have been in the running before, this marks the first time an Indiana physician has been accorded this honor.

Dr. and Mrs. Yoder flew to California to receive the award from Dr. Cline, president of the American Medical Association. Arriving at 4:30 a.m., Doctor Yoder had very little rest until the sessions came to an end, as he was in constant demand for radio programs, television shows and press conferences. (Pictures on page 36.) No doubt one of the highlights in Doctor Yoder's experiences as a national celebrity was his participation in a television program from the big CBS studio in Hollywood, from whose stage the Hollywood stars put on their nation-wide television shows.

Doctor Yoder's remarks, that he had done nothing outstanding during his fifty years as a physician unless it be that he has always been a "buck private" in the ranks of medicine drew praise from the Delegates. That Doctor Yoder is a true example of the family doctor who has brought about the respect of the public for their family physician, was the comment heard from every side.

Indiana shared the limelight again when Dr. Earl W. Mericle, Indianapolis, chairman of the Public Relations Committee of the association, addressed a two-day Public Relations meeting on "Your Patient and His Big Bills."

## SESSION BREAKS ALL RECORDS

With one of the largest registrations for a clinical session, those in attendance felt it was one of the best sessions in the history of the AMA. A

total of 3,550 physicians registered, with an additional registration of 3,056 guests, establishing a new high for the clinical session. The largest number of exhibits ever to be shown at the mid-winter meeting were outstanding in their quality.

Those in attendance had a time attempting to get around to see and hear everything on the busy program, as it was crammed with interesting talks by outstanding people in the news today.

## CLINE SOUNDS CALL TO ACTION

Dr. John W. Cline, San Francisco, president of the AMA, sounded a call to action in his opening address before the House of Delegates. Doctor Cline said, "It may not be easy to stop the progress toward socialism, but it is far easier and more realistic to halt it than to try and eliminate it after it has become an accomplished fact. I urge you, not as members of this association, but as citizens, to act as individuals, in informal groups and in association with others. I urge you to be militant and to be determined. The time to begin is not six months hence, but now."

He pointed out that a profession with high ethical standards and devoted to public welfare is not immune to scurrilous attack or smear by demagogues and socialist-minded bureaucrats.

"Necessity has taught us to meet such assaults vigorously and effectively," he said. "As a consequence, American Medicine is no longer a wise choice as a whipping boy."

## LEGION PROMISES SUPPORT

Speaking before the House of Delegates, Donald R. Wilson, Clarksburg, West Virginia, National Commander of the American Legion, said, "the three million members of the Legion stand shoulder to shoulder with you, as doctors, in your battle to overcome the encroaching forces of socialized medicine."

"No organization," he said, "is more determined to have the genius of the American doctor unshackled by any form of socialism of American medicine."

Attorney Wilson said, "It is our firm and unalterable belief that the American doctor, when left to his own inspired resources, will provide the basic answers to the problems of medical care, which face not only the American veteran, but also the American people at large."

\* Delegate from the Indiana State Medical Association to the House of Delegates of the American Medical Association.



**\$500,000 VOTED**

The AMA voted another half million dollars to organized medicine's effort to provide needed financial aid to the nation's medical schools. This money will be turned over to the Medical Education Foundation for distribution among the nation's 79 medical schools.

**COMMISSION MEMBERS ANNOUNCED**

The Board of Trustees of the AMA announced the AMA representatives for the Joint Commission on Hospitals. Following months of discussion and many bitter controversies, the new Joint Commission of Hospitals will begin its work on the accreditation of hospitals within the next few months.

The joint commission representing the American Medical Association, the American College of Surgeons, the American College of Physicians, and the American Hospital Association, will be composed of 18 members, six from the AMA and AHA and three each from the ACS and ACP. The AMA representatives on the commission will be: Dr. Rolland J. Whitacre, East Cleveland, Ohio; Dr. Herman G. Weiskotten, Syracuse, N. Y.; Dr. Julian P. Price, Florence, South Carolina; Dr. Dwight H. Murray, Napa, California; Dr. Gunnar Gundersen, LaCrosse, Wisconsin, and Dr. Stanley A. Truman, Oakland, California.

**MAKE TV HISTORY**

Television history was made during the clinical session when the first transcontinental transmission of color television was broadcast from the session to medical audiences in Chicago and New York. The operation telecast on this network in color was a "Coarctation on the Heart" of a twenty-year-old man. The operation was performed by Dr. John C. Jones, eminent thoracic surgeon and associate professor in surgery at the University of Southern California School of Medicine.

**7,000 HEAR TAFT AND BYRD**

Two top-ranking U. S. senators—one a republican and the other a democrat—linked forces to drive home a warning against the dangers of "creeping socialism." Senator Robert A. Taft, Ohio's Republican senator who has declared himself for the Republican presidential nomination in 1952, and Senator Harry F. Byrd, out-spoken Virginia Democrat, appeared before a throng of 7,000 at a special meeting of the AMA House of Delegates in the Shrine Auditorium. The meeting which was thrown open to the public saw hundreds turned away and the SRO signs were hung out early.

The program was broadcast coast-to-coast and both speakers took the present administration to task for leading the American people into bondage through its program of welfare. The complete text of these two speeches appears in the December 15 issue of *The Journal of the A.M.A.*

**HOUSE ACTIONS**

Actions of the House on the many items of business brought before it are as follows:

**Resolution to Hold Interim Session of House in Chicago;** presented by Ohio. It being their feeling that the Clinical session and the meeting of the House could be separated and the House could meet in Chicago, thereby reducing amount of time required and expense for travel. Referred to the Council on Scientific Assembly for further study; no action taken at this meeting.

**Resolution Calling for Council on Medical Education and Hospitals to Assign Number of Internships in Relationship to Number of Interns Available,** in order to bring an end to competition for interns, was approved.

**Resolution to Pay AMA President and President-elect Per Diem When Away From Home** and resolution to pay AMA President \$5,000 to \$10,000 per year during his term of office. Approved in principle and left to discretion of Board of Trustees to establish the amount of the per diem.

**Blue Shield Approved For Dependents' Medical Care.** Text of approved resolution is as follows: "If, in the independent judgment of Department of Defense or Congress, the welfare of our preparedness program requires that dependents of members of our armed forces receive medical care on a service basis, then the medical profession stands ready to provide such service through Blue Shield and other medical society-sponsored plans." This may sound innocuous but (1) it gives Blue Shield strong recognition by the AMA; (2) it strengthens position of American Hospital Assn., which took a similar stand at recent annual meeting in St. Louis; and (3) it may conceivably serve to influence consideration which is now being given by Department of Defense and armed services to utilization of voluntary prepayment plans in providing health care for dependents (WRMS No. 233).

**Resolution Supporting and Encouraging Fluoridation of Water Supplies,** was approved.

**Resolution on Implementation of Washington, D. C., Office** and calling for the purchase of property in Washington, D. C., for the Washington Office of the AMA was referred to the Board of Trustees for further study toward acquiring property at the opportune time.

**Resolution on Emergency Seating of Substitute Delegate** upon authorization of other delegates when either the regular or alternate delegate is unable to serve, was referred to the Committee on Constitution and By-laws for further study.

**Resolution Clarifying Atlantic City Resolution Calling for Congressional Investigation** of teaching practices in the nation's public schools, was approved.

**Resolution Opposing Granting Deferments to Chiropractors on Same Basis as Physicians,** introduced by Indiana, was approved.

**Resolution on It Being Unethical for Physician to Increase Fees on Patients Having Insurance.** The reference committee called attention to the fact that this was presently covered in the Code of Ethics and was a matter for local grievance committees. The resolution was disapproved.



**Resolution Calling for Discontinuance of Mandatory Payment of Delinquent Dues Before a Member Could Be Accepted in Good Standing.** This resolution called for the encouragement and acceptance of all physicians in the AMA without the necessity of their payment of delinquent dues. The resolution was not approved, but did empower the Board of Trustees to negotiate with each state on this matter.

**Resolution Calling on Blue Cross to Pay for Physician's Facilities.** Resolution not approved, as it was felt the relationship between Blue Cross, Blue Shield, Physicians and Hospitals was a matter to be handled at the state and local levels.

**Special Committee Order to Study Veteran Problems.** For several years AMA has been trying to do something about manifold problems dealing with medical and hospital care of war veterans. Perhaps the most controversial is the matter of government responsibility for non-service-connected cases—whether they should continue to be eligible for beds in veterans hospitals, and if not, how they might be cared for under private auspices. Again, the so-called Shoulders Plan was introduced, providing that Washington contract and pay for memberships in voluntary health service plans to cover veterans with non-service-connected disabilities who were unable to pay for medical care. It was debated with spirit at reference committee hearings. House of Delegates passed the reference committee recommendation that the board of trustees appoint a special committee to study the Shoulders Plan and other ramifications of veterans' care. A noteworthy angle is that proposed committee is directed to consult with hospital, insurance, veterans and other interested organizations in arriving at its conclusions.

**Revised Hess Report.** On recommendation of Board of Trustees, House of Delegates adopted a policy statement on physician-hospital relations which supplants the controversial "Hess Report." Although philosophy underlying latter is retained in this new protocol, its language has been altered so as to make *physicians alone* accountable for any deviations from the line. Threat of punitive or disciplinary action against "non-cooperating" hospital, as set forth in previous policy, has been eliminated. Latest version of Hess Report offers following principles for guidance of individual practitioners and medical societies toward solution of local controversies over employment of doctors by hospitals:

1. A physician should not dispose of his professional attainments or services to any hospital, corporation or lay body by whatever name called or however organized under terms or conditions which permit the sale of the services of that physician by such agency for a fee.

2. Where a hospital is not selling the services of a physician, the financial arrangement if any between the hospital and the physician properly may be placed on any mutually satisfactory basis. This refers to the remuneration of a physician for teaching or research or charitable services or the like. Corporations or other

lay bodies properly may provide such services and employ or otherwise engage doctors for those purposes.

3. The practice of anesthesiology, pathology, physical medicine and radiology are an integral part of the practice of medicine in the same category as the practice of surgery, internal medicine or any other designated field of medicine. (28-30) (44) (45) (52).

**Prepay Contracts Involved.** An aggravating factor, says the adopted report, has been practice of including certain medical services in contracts of voluntary hospital service plans. Blue Shield and Blue Cross are urged, accordingly, to write up their contracts so that they will cover, respectively, medical and hospital care exclusively. It is recommended that every state and local medical society form a committee on hospital and professional relations to hear complaints on professional or economic relations between physicians and hospitals. Cooperation of state and local hospital associations also is urged and "state medical associations and component county medical societies could well effect liaison with these organizations in the settlement of problems involving physician relationships."

A lengthy report and discussion covering many changes in the Constitution and By-laws of the AMA closed the last meeting of the House of Delegates. Changes approved were so numerous we hesitate to attempt even to report on this matter. While many of the changes were made necessary by the discontinuance of the "Fellowship" and "Service Fellow" classifications, many other changes were effected, many dealing with ethics and the practice of medicine and a special study of House committees and their responsibilities. We would suggest that members follow closely the report in *The Journal of the AMA* for further information on these matters.

#### AMA DATES

1952 Annual Session—Chicago, June 9-13  
 1952 Clinical Session—Denver, December 2-5  
 1953 Annual Session—New York, June 1-5  
 1953 Clinical Session—St. Louis, December 1-4  
 1954 Annual Session—San Francisco, June 21-25  
 1954 Clinical Session—Miami, November 30-December 3

Those from Indiana who were registered for the Los Angeles meeting were as follows:

Balkema, Catherine M., Lafayette  
 Blix, Fred M., Ladoga  
 Caylor, Harold P., Bluffton  
 Caylor, Truman E., Bluffton  
 Crockett, Franklin S., Lafayette  
 Eikenberry, H. W., Indianapolis  
 Ellison, Alfred, South Bend  
 Gibson, Greta M., Indianapolis  
 Giordano, Alfred S., South Bend  
 Goodman, Hubert T., Terre Haute  
 Hamer, Homer G., Indianapolis  
 Haslem, John R., Terre Haute  
 Herzer, C. C., Evansville  
 Irey, P. R., Plymouth

(Continued on page 48)

Jarrett, Paul E., Anderson  
 Kahan, Harry L., Gary  
 Kinzie, M. Dale, Goshen  
 Kirch, Leo N., Evansville  
 Kirtley, William R., Indianapolis  
 LaBier, Clarence R., Terre Haute  
 McCaskey, Carl H., Indianapolis  
 McDonald, Frank C., New Castle  
 Plain, George, South Bend  
 Polhemus, W. C., Anderson  
 Prenatt, Francis, Madison

Roach, Carroll E., Indianapolis  
 Rothrock, Philip W., Lafayette  
 Sensenich, R. L., South Bend  
 Seyler, Anna Grace, Crown Point  
 Stellner, Howard A., Fort Wayne  
 Stygall, James H., Indianapolis  
 Tirman, Wallace S., Bluffton  
 Washburn, Will W., Lafayette  
 Welborn, Mell B., Evansville  
 Yoder, A. C., Goshen  
 Waggener, Jas. A., Indianapolis

## *Letter to the Editor*

### HELP FIGHT COMMUNISM

People who are authorities on the subject of Communism, particularly those victims who have escaped prison camps, or have fled from behind the iron curtain, tell us facts in no uncertain terms. They tell us that Stalin's most dependable and valuable ally here in these United States is our consistent apathy, gross indifference and utter stupidity in evaluating the threat of the triumph of Communism in America.

As professional men we are in a most strategic position for waging a campaign against Red Fascism. How?

We enjoy the confidence, respect and trust not only of our patients but of the citizenry at large. We owe our all to our country and our professions with their joint rich heritages. It is now high time that we begin to repay that debt.

Communism (right name—Stalinist State Slavery), the deadly enemy of our free government, has gained a foothold so unbelievably strong that it will take the combined heroic efforts of all citizens to defeat its purpose. What purpose? The conquering of the world! For the Red leaders to stop short of that goal would be to invite eventual defeat. They know this to be a fact. That is the reason the iron curtain hides its slave labor camps and all other failures of its depraving system.

How much truth is there in all this talk about menace? Are they so strong? Are they controlled, body and soul, by Moscow? Have they infiltrated our armed forces, government, offices, schools, unions, yes, even our churches?

There is a wealth of material setting out the answers to the above questions if we will take time to do some reading and studying. We can also use our influence in stimulating interest in others. But there is always the stock answer, "I don't have the time." The "time" may be closer than one would think when you will do what you are told, including practicing in a location dictated by someone else. We must learn to realize that totalitarian slave labor camps need many professional men to take care of the "workers." So-called workers are merely

dollar counterparts in value in the free enterprise system. Human life to the Red Commissars as such are as nothing—only to be considered by the work that can be turned out. So, their bodies must be kept fit as possible on the starvation diet that is provided.

We have been fighting socialistic medicine and dentistry. These are the "effects" that have come from several causes. The chief cause is theoretic Communism. Get rid of the cause and you eliminate the effect.

What can you do? Place educational reading matter upon your reception room tables. During the recent all-out campaign to combat the trends mentioned above it was found that very efficient help was obtained by providing reading material setting out OUR side of the question where our patients had easy access to it. An awakened and alarmed public is an armed public. Let's do it again.

The following three publications are recommended

THE FREEMAN—issued fortnightly—\$5.00 a year.

240 Madison Avenue, New York 16, N. Y.

NATIONAL REPUBLIC—issued monthly—\$2.00 a year.

511 Eleventh Street, N. W., Washington, D. C.

THE CHALLENGE—issued monthly—\$1.50 a year.

373 West 52nd Street, Room 7, New York 19, N. Y.

*The Challenge* is the bulletin of "The Association of Former Political Prisoners of Soviet Labor Camps." This little publication tears the iron curtain to shreds and gives the lie to much of the double talk and many of the explanations of the Soviets. It is graphically illustrated.

All of these publications are recommended by the Un-American Activities Committee of the American Legion.

Lester D. Bibler, M.D.,  
 Indianapolis.



# The Fourth Estate Looks At Medicine

This section of **THE JOURNAL** is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

## HOOSIER DOCTORS SHOW WAY IN ANTI-SOCIALIZATION FIGHT

Physicians in Indiana apparently believe that the most effective way to beat a would-be competitor is to provide a better product.

Although we don't hear so much as formerly concerning efforts to provide a federal health service which, for all practical purposes, amounts to a socialization of medicine, the fight for continuation of the free enterprise system in the medical field is being carried forward with undiminished vigor.

For one thing, a number of Hoosier doctors have made trips to England to get a closer view of the operations of that nation's socialized medicine program. This closer view provides them with many facts and figures which assist them in their battle against such a plan in this country.

But perhaps the most important thing which the 5,000 doctors of the state are doing to combat efforts to socialize their field of endeavor, is a program of self-examination to determine what are the major complaints patients now have against the service provided.

The Indiana Medical Association has a doctor-patient grievance committee which operates with the co-operation of local medical societies. Complaints which people may have regarding the services of their physicians are brought to attention and efforts made to correct whatever the trouble may be. In effect, Hoosier doctors are saying: "Tell us just what you don't like about our service, and we'll make a sincere effort to improve it."

By and large, our Indiana doctors are providing a splendid service. They recognize, however, that there are those among them who do not measure up to the high standards of the practice from time to time—just as there must be in any field of human endeavor—either professional or non-professional. They deserve commendation for efforts to improve a service which already is excellent with very few exceptions.

As pointed out recently by Hoosier Day Columnist Frank White, "After three years of socialistic experiments British health service is short on health and low on service. It is bankrupt."

But despite the failure of the British program, there are still some in this country who have the mistaken idea that Americans would profit by such a plan. Indiana's doctors, and the vast majority of those in the rest of the United States, are doing everything they can to show that the free enter-

prise system is the best system in the field of medicine, just as it is in any other. They deserve our encouragement and help in their fight.

—*Shelbyville News.*

## WHY VETERANS LACK DOCTORS

Dr. Joel T. Boone, medical director of the veterans administration, made the statement in Chicago that the country is going to have to "allocate" physicians, dentists, and nurses if the VA is unable to sign up more of them for its hospitals. "Allocation" is a polite word for drafting professional people, and, in the case of Dr. Boone's hospitals, drafting them for civilian jobs. Veterans administration personnel are not in military service.

There is one good reason why Dr. Boone finds it difficult to staff many of his hospitals. Pork barrel artists in the Truman administration and in congress built many of them, against all advice from the medical profession, in out of the way places where doctors do not want to live and practice.

In 1943, Carl Vinson, the chairman of the house armed services committee, grabbed off a 900 bed naval hospital for Dublin, Ga., in his congressional district, with the provision in the law that the hospital should revert to the veterans administration. Dublin, a town of about 8,000 before Rep. Vinson began showering blessings on it, hasn't even passenger train service. Old Tawm Connally, head of the senate foreign relations committee, did as well for his home town, Marlin, Tex., with a VA hospital that doctors shun.

Dr. Boone is in his present job because Veterans Administrator Carl R. Gray, Jr., fired Boone's predecessor, Dr. Paul B. Magnuson, of Chicago. Dr. Magnuson got in bad with the politicians because of his insistence, not always successful, that new VA hospitals should be located in metropolitan areas, where plenty of good physicians are available for part time service.

The veterans administration renders many useful and necessary services, and a lot more that are uncalled for. There is no reason why it should treat veterans for nonservice connected ailments.

The VA probably has enough staff today to care for veterans whose ailments can be traced to their military service. It hasn't enough to operate a political racket, and the physicians of the country are under no obligation to assist in that racket by accepting assignments to pork barrel hospitals.

—*Chicago Tribune.*



## Deaths

Charles Hupe, M.D., of Lafayette, died on September 18, at the age of ninety-four. According to American Medical Association records, he was the second oldest physician in the nation. Doctor Hupe was a graduate of the University of Greifswald, Germany, in 1882, and came to the United States the following year. He had practiced continuously in Lafayette since that time. Doctor Hupe had been treasurer of the Tippecanoe County Medical Society for forty-five years. He was an honorary member of that society and the Indiana State Medical Association, and was a member of the American Medical Association.

John C. Bigham, M.D., of Batesville, died on November 24, after a long illness. He was fifty-eight years of age and had practiced in the vicinity of Batesville for more than thirty years. He graduated from the University of Louisville School of Medicine in 1920, and was a former member of the Ripley County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Addison G. Moore, M.D., formerly of Delphi, died on November 16, at Phoenix, Arizona, after a brief illness. He was fifty-six. He was a 1928 graduate of Indiana University School of Medicine and was a former member of the Carroll County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Lazarus L. Witt, M.D., of Indianapolis, died on November 14, at the age of eighty-seven. He was a graduate of the Baltimore Medical College, Baltimore, in 1893, and had practiced in Indianapolis since 1890.

Irving A. Whitlatch, M.D., of Milan, died on November 13, at the age of seventy. He graduated from the University School of Medicine, of Louisville, Kentucky, in 1911, and had practiced in Milan until his retirement in 1943.

Clarence H. Schulz, M.D., of LaGrange, died on November 17, at the age of fifty. He was a 1926 graduate of Indiana University School of Medicine, and practiced in Hobart until 1932, when he moved to LaGrange. Doctor Schulz was a member of the LaGrange County Medical Society and the Indiana State Medical Association, and was a fellow of the American Medical Association.

John T. Wheeler, M.D., of Indianapolis, died on December 4, at the age of eighty-four. He was a graduate of the Indiana Medical College, School of Medicine of Purdue University, of Indianapolis, in 1907, and had served as professor of anatomy at the Indiana University School of Dentistry from 1906 until he retired in 1940. He continued his medical practice until four years ago. He had practiced at Rockport before coming to Indianapolis. Doctor Wheeler was an Honorary member of the Indianapolis Medical Society and the Indiana State Medical Association, and was a fellow of the American Medical Association.

Iva M. Miller, M.D., of Indianapolis, died on December 5, after a long illness. She was seventy-one years of age. A graduate of the Chicago College of Medicine and Surgery, in 1906, Doctor Miller went to China in 1910 as a medical missionary and stayed for twenty years as head of the Methodist Mission Hospital at Tientsin. Upon her return to the United States, she practiced in Hillsboro, Illinois, and in Indianapolis. Doctor Miller was a member of the Indianapolis Medical Society and the Indiana State Medical Association, and was a fellow of the American Medical Association.

Joseph W. Donovan, M.D., of Morocco, died on November 3, at the age of thirty-one. He was a 1946 graduate of the New York Medical College, New York, and had practiced in Morocco since May 1950. He was a member of the Jasper-Newton County Medical Society, the Indiana State Medical Association, and the American Medical Association.

George Edgar Hoffman, M.D., of Rochester, died suddenly on November 7. He was eighty-five years of age. He was a graduate of the University of Michigan Medical School, at Ann Arbor, in 1893, and had practiced in Rochester since that time, with the exception of eight years which were spent as assistant superintendent of the Northern Indiana Hospital, at Logansport.

David E. Mavity, M.D., of Fowler, died on November 16, after a long illness. He was eighty-one years of age. After his graduation from the Gross Medical College, in Denver, Colorado, in 1892, he began the practice of medicine in Fowler, where he had practiced ever since. Doctor Mavity was an Honorary member of the Benton County Medical Society and the Indiana State Medical Association, and was a member of the American Medical Association.

## News Notes

The Psychosomatic Forum which is held at 8:00 p.m. on the first Monday night of each month in the Clinical Auditorium of the Clinical Building at Indiana University Medical Center, announces that on January 7 Drs. T. F. Schlaegel, Jr., and Philip F. D. Seitz will discuss "Age, Sex and Psychodynamics in the Eye Injuries of Children"; and Dr. Ralph Reitan will discuss "The Use of Statistics in Medical Research." On February 4 Dr. Louis W. Nie will discuss "Iatrogenesis in Psychosomatic Disorders."

Dr. Gerald F. Kempf, of Indianapolis, has been appointed superintendent of Indianapolis General Hospital, to succeed Dr. Charles W. Myers, who has resigned after twenty years in that capacity. Doctor Kempf has been city health director since 1946. Prior to that he spent sixteen years as research physician in the Lilly Clinical Research Laboratory at Indianapolis General Hospital, and formerly taught physiology at the Indiana University School of Medicine at Bloomington. Dr. Henry G. Nester, who is succeeding Doctor Kempf in the city health post, is a former head of the Department of Physiology and Health at Butler University, in Indianapolis. He is a World War II veteran, and has been in private practice in Indianapolis.

Dr. William S. Keezer has opened offices for the practice of medicine in Vincennes and in Monroe City, alternating between the two. He spent four years with the U. S. Army Ordnance Department in Burma and India. Doctor Keezer is a 1950 graduate of Indiana University School of Medicine. He interned at St. Mary's Hospital in East St. Louis, and took a residency in geriatrics at the VA Hospital at Jefferson Barracks, Missouri.

Dr. A. L. Roby has opened an office in Jeffersonville for the practice of pediatrics. A veteran of World War II and the Korean War, Doctor Roby is a graduate of the University of Louisville School of Medicine. He received postgraduate training in pediatrics at Louisville General Hospital and at the Children's Hospital in New York.

Dr. L. E. Burney, Indiana State Health Commissioner, was elected president of the Association of State and Territorial Health Officers recently. He was also appointed a Trustee of the American Board of Preventive Medicine and Public Health.

Dr. G. A. Dickinson has returned to Petersburg, where he has opened an office for the practice of medicine. He practiced there for eleven years, prior to entrance into the Army in 1941. Following his release from service in 1946, he operated a hospital in Hartford, Kentucky, until 1950, when he accepted an appointment with the VA Hospital at Jackson, Mississippi.

Dr. Thomas A. Elliott, who recently completed specialty work in internal medicine at the Ochsner Clinic in New Orleans, has returned to Elkhart, where he will be associated with his father, Dr. L. A. Elliott. The junior Doctor Elliott graduated from Northwestern University School of Medicine in 1945, and interned at Cook County Hospital in Chicago. He served with the Army for approximately two years, and spent a year in general practice before going to New Orleans on a fellowship in internal medicine.

Dr. Robert J. Fenneman is now associated in the practice of ophthalmology with Drs. C. R. Buikstra, John E. Alexander and John J. Cacia in the Hulman Building in Evansville. A graduate of Indiana University School of Medicine, Doctor Fenneman took postgraduate work at Wayne University in Detroit, and at the Bellevue Medical Center in New York.

Dr. R. W. Oliphant, of Terre Haute, was elected vice-president of the Aesculapian Society of the Wabash Valley recently, and Dr. J. O. Conklin, of Terre Haute, was re-elected treasurer. The society held its 105th semi-annual meeting in Terre Haute in October, and Dr. A. W. Cavins and Dr. R. D. Solomon, both of Terre Haute, were on the professional program.

Dr. Louis F. Raymond has opened an office for the practice of ophthalmology and otolaryngology in Decatur. He is a graduate of Loyola University of Chicago, and practiced in Chicago and New York.

Dr. William C. Robertson has moved to Chester-ton from LaGrange, where he has practiced for the past three years.



Nine hundred and three initiates were received into fellowship by the American College of Surgeons at the convocation on November 9 at the thirty-seventh annual Clinical Congress in San Francisco. Included were the following Indiana physicians: Edwin W. Dyar, Indianapolis; Edwin Ray Eaton, Indianapolis; Richard E. Estlick, Fort Wayne; Nathaniel D. Ewing, Vincennes; John E. Freed, Jr., Terre Haute; Bernard R. Hall, Logansport; Richard R. Hughes, Lafayette; George M. Johnson, Richmond; Lewis Jolly, Madison; Joseph L. Larmore, Anderson; Edwin A. Lawrence, Indianapolis; Joseph C. Manning, Indianapolis; Walter K. Robinson, Gary; Henry Joseph Rosevear, Hammond; Frederick H. Simmons, Marion; James M. Wilson, South Bend; Theodore C. Zeman, Hammond; H. Haskell Ziperman, Indianapolis.

The Cancer Cytology Center of the Dade County Cancer Institute, an affiliate of the Medical Research Foundation of Dade County in Miami, Florida, has announced its first one-week seminar for physicians to be held at the Institute from January 14th to 19th inclusive. Applications for registration, limited to 35 physicians, will be accepted through January 12th.

The Paul Coble Post of the American Legion is taking an active interest in the Nurses Training Program Fund of the 40 and 8. More than 100 student nurses in the state of Indiana were aided in their training by this fund during the past year. Members of the Post are anxious to enlist the support of the medical and dental professions. The fund was originated by a physician and has received most of its finances from lay sources for several years. Contributions may be mailed to the Paul Coble Post, 447 E. 38th Street, Indianapolis. Arrangements have been made to credit all donations from outside Marion County to the Voiture of the 40 and 8 in the doctor's home county. Contributions are Federal Income Tax exempt.

A panel discussion on "Diabetes" will be held in Cincinnati at the College of Medicine auditorium on Thursday, January 17, at 8 p.m. Discussants will be members of the Council of the American Diabetes Association. The meeting, to which all physicians are cordially invited, is sponsored by the Council on Diabetes of the Cincinnati Public Health Federation.

Physicians who plan to attend may submit questions to the panel by mailing them, in advance of the meeting, to the Council on Diabetes, 312 West Ninth Street, Cincinnati 2, Ohio.

The Clinical Conference of the Chicago Medical Society will be held in the Palmer house on March 4, 5, 6, and 7. In response to popular demand, an increased number of demonstrations or work shop periods will be included in addition to the regular series of lectures. Subjects to be presented will be of interest to general practitioners and specialists alike. Scientific and technical exhibits will be on display. The complete program will be mailed upon request to The Chicago Medical Society, 86 E. Randolph Street, Chicago 1.

A native of Howe, Dr. Philip E. Yunker has returned there to establish an office for the practice of medicine and surgery. A graduate of Indiana University School of Medicine, he has practiced in Evansville since 1933, except for four years of service in the armed forces.

Dr. Amos C. Michael, who has been associated with the Indiana University School of Medicine since 1933, has resigned to accept a position as associate professor of pathology at the University of South Dakota School of Medicine in Vermillion, South Dakota.

Following his release from the Air Force recently, Dr. Thomas A. Stump has opened an office for the general practice of medicine at 422 East 23rd Street in Indianapolis. Doctor Stump is a graduate of Indiana University School of Medicine, interned at Indianapolis General Hospital, and served a year's residency at Sunnyside Sanitarium. As a captain in the Medical Corps, he served with the Third Bomb Wing in Japan and Korea.

Dr. James P. Shortall has opened an office in Michigan City for the practice of medicine. A 1941 graduate of Loyola University School of Medicine, he has been with the Little Company of Mary Hospital in Chicago since that time.

Dr. Thomas E. Slimp has begun the practice of medicine in Logansport. He is a graduate of the Syracuse University College of Medicine, in New York, and interned at Santa Barbara, California. He took postgraduate work at the Barnes Hospital, Washington University, in St. Louis, and spent six and one-half years in the Navy.

Dr. Charles Yale has moved to Winamac, where he has opened an office for the practice of medicine. A graduate of Indiana University School of Medicine, he interned at Indianapolis General Hospital, and was a resident at the Colorado State Hospital in Pueblo, Colorado.



## Indiana University News Notes

Dr. Harris B. Shumacker, Jr., has gone to Japan and Korea as a consultant to the armed services on the treatment of frostbite, a subject on which he has been doing extensive research. Doctor Shumacker expects to spend about three weeks with field hospital units in Korea.

The Riley Cheer Guild has performed another thoughtful service by redecorating the "Parents Room" at Riley hospital. The room has been repainted and new draperies, rug and furniture have been added, making it a more cheerful place for parents to wait while visiting children who are in surgery or in critical condition.

Recognition has come to the Medical Center from two national organizations in recent weeks, based on exhibits prepared by the Illustration Department of the Medical Center for the Department of Radiology. An exhibit at the meeting of the American Roentgen Ray Society meeting in Washington, D. C., was awarded the Society's Certificate of Merit. A radiological exhibit at the Toronto meeting of the American Academy of Pediatrics, was voted the "best exhibit of the year" and will occupy a place of honor in the Pediatric Section during the American Medical Association meeting in Chicago next June.

James Durlacher, radiation physicist, has passed the examination of the American Board of Radiological Physics and has been certified as a Consultant in Radiological Physics.

Dr. Richard Silver has been notified that he has successfully passed the examination of the American Board of Radiology.

Announcement has been made of the appointment of Raymond A. Dault as manager of the Student Union Building which is under construction on the Medical Center campus and tentatively scheduled to open early in 1953. Mr. Dault will take an active part in the selection of supplies and other arrangements for the actual operation of the building during the coming year.

For the past 14 months Mr. Dault has been the assistant manager of the Indiana Union on the Bloomington campus.

### A.M.A. WASHINGTON OFFICE NEWS

#### Veterans Administration May Add 9,000 Psychosis Cases to Bed Load

Veterans Administration faces an almost-certain crisis in attempting to comply with Public Law 239. This provides that *service-connection may be presumed* for all psychosis cases developing within two years after discharge from service for World War II veterans and those in service since start of the Korean War.

VA estimates that the law may require it to provide *immediate hospitalization or out-patient care* for as many as 9,000 veterans, who before passage of the law were listed as non-service connected and *entitled to hospitalization—but not out-patient care—only if facilities were available*.

VA can see no apparent way out of the dilemma. All of its 53,000 neuro-psychiatric beds now are occupied, and the trend has been toward reducing rather than expanding the total because of shortages of medical personnel. While a num-

ber of these hospitalized cases are non-service, and therefore of lower priority than the new cases, the veterans obviously can't be turned out. Current turnover rate is so low—4 percent a year—as to offer only a partial solution. VA will have to limit incoming patients to service-connected cases until all 9,000 have been taken care of. An undetermined number of the 9,000 are now in state institutions and will probably remain there with VA paying the bill from here on.

Meanwhile, VA has delayed sending out regulations under the new law because the "intent of Congress" is not entirely clear. One question is whether to declare *all of the 9000 cases eligible*, or to set up a screening process for eliminating those which *could not even be presumed to be service-connected*—those resulting from auto accidents, for example.

## Society Reports

### INDIANA STATE MEDICAL ASSOCIATION

#### EXECUTIVE COMMITTEE

November 25, 1951

Roll call showed the following present: W. L. Portteus, M.D., chairman; J. William Wright, M.D.; Paul D. Crimm, M.D.; W. U. Kennedy, M.D.; Roy V. Myers, M.D.

Frank B. Ramsey, M.D., editor of *THE JOURNAL*; Albert Stump, attorney; James A. Waggener, executive secretary.

#### Guests:

Maurice O. Hunt, director	}	Department of Public Welfare
Frank M. Hall, M.D., medical advisor		
Miss Ethel G. Harrison		

#### Membership Report

Number of members November 21, 1951	3,645*
Number of members November 21, 1950	3,663
Loss over last year	18
Number of members, December 31, 1950	3,689

\*Includes 46—in military service (gratis)

150—\$10.00 members (residents and interns)

210—senior members

36—members, dues remitted by Council

Number who have paid 1951 AMA dues...2,878

Number who have paid 1950 AMA dues...2,866

In discussing the membership report the committee instructed the secretary to prepare a list of non-members and send to the secretaries of the respective counties and make inquiry if any are eligible to membership.

#### Treasurer's Office

On motion of Drs. Myers and Wright, the George S. Olive Company is to be employed to make the annual audit of the association and *JOURNAL* books for 1951.

#### Headquarters Office

Statements of receipts and expenditures and report on the budget for October for the association and *THE JOURNAL* were approved.

#### 1951 Annual Session, Indianapolis,

October 29, 30 and 31, 1951

*Baby Development Clinic, Chicago.* Upon motion of Drs. Crimm and Kennedy, the association will not permit the Baby Development Clinic to make contacts using the name of the Indiana State Medical Association as a sponsor, as this is against the policy of the association.

#### 1952 Annual Session, Indianapolis

*Dates of meeting.* Upon motion of Drs. Kennedy and Crimm, the dates for the 1952 annual session were established as October 28, 29 and 30, to be held at the Murat Temple, Indianapolis.

*Exhibit rules.* By consent the committee requested the secretary to contact the American Medical Association for their ruling in accepting exhibits, and to bring up the matter for further discussion at the next meeting of the committee.

#### 1953 Annual Session, French Lick

By consent the committee selected Monday, Tuesday and Wednesday October 19, 20, 21 as the dates for the 1953 meeting at French Lick.

#### Legislative Matters

Upon motion of Drs. Wright and Kennedy the name of the executive secretary is to be filed on the reports as association lobbyist.

#### Organization Matters

Upon motion of Drs. Crimm and Kennedy the Executive Committee referred to the Council the matter of receiving resolutions for the House of Delegates. It feels that the Council should establish rules designating how and when resolutions are to be received in order to be acted upon by the House.

*Placement of scholarship recipients.* The assignment of communities to physicians on scholarships is to be handled by the Committee on Medical and Nursing School Scholarships. This committee is to be continued until such time as all present scholarship students are placed.

*Contribution to National Society for Medical Research.* On motion of Drs. Myers and Kennedy, \$100.00 was voted to the National Society for Medical Research.

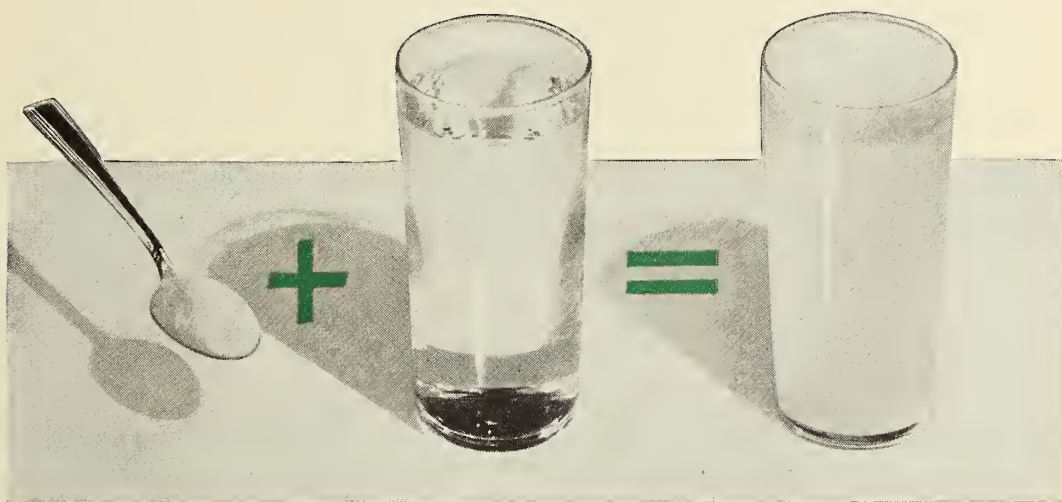
*Trust fund for medical research.* Upon motion of Drs. Wright and Myers, the committee approved in principle the suggestion made by Dr. J. W. Denny, chairman of the Committee on Medical Education and Hospitals to Dr. Wright, in which he proposed the establishment of a trust fund for use in medical research by the University with the monies obtained through the campaign to help medical education.

Request of the Committee on Physician-Hospital Relationship for permission to issue a bulletin, to be enclosed with the News Flashes, and the aims and policies of the committee were approved upon motion of Drs. Wright and Myers.

Request of Lambert Mailing Company to use the mailing list for addressing a brochure for the Steele Hobby Shop was denied because of this being a commercial venture.

Request of the Continental News Photo Service was denied by consent.

## Normohydration FOR BOWEL REGULATION



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### The Journal

The editor of THE JOURNAL was given permission to do anything he feels necessary to promote the plaque proposed by the American Medical Association, on motion of Drs. Wright and Crimm.

### Future Meetings

January 18-19, 1952—

Annual Congress on Industrial Health, Pittsburgh. By consent, it was agreed that the chairman of the Committee on Industrial Health should attend this meeting.

February 28-March 1, 1952—

National Rural Health Conference, Denver. By consent, it was agreed that the chairman of the Committee on Rural Health should attend this conference.

### Welfare Board

Maurice O. Hunt, director of the Department of Public Welfare, Miss Ethel G. Harrison, and Frank M. Hall, M.D., medical advisor, appeared before the committee for a discussion of the welfare situation.

There being no further business, the committee adjourned to meet again at 2:00 p.m., Saturday, January 12, 1952, at the Columbia Club, Indianapolis.

## COUNCILOR DISTRICT MEETING

### THIRTEENTH DISTRICT

One hundred and ten members and their wives attended the district meeting at South Bend on Wednesday, November 14. The morning program was held in the South Bend Clinic, with a luncheon, afternoon and evening meetings being held at the LaSalle Hotel. The Auxiliary held its luncheon and afternoon program at Healthwin Hospital.

The district accepted the invitation of the Elkhart County Medical Society to hold its 1952 meeting in Elkhart during the month of November.

Officers elected for the coming year are as follows: president, F. S. Martin, M.D., Goshen; vice-president, J. E. Luzadder, M.D., New Carlisle; and O. E. Wilson, M.D., Elkhart, was re-elected secretary-treasurer.

The South Bend Medical Foundation acted as host for the morning program which opened at 10:00 a.m. with a paper by Jene R. Bennet, M.D., on "Recent Progress in Rh Factor Studies." A paper on "Recent Progress in Diagnosis and Treatment of Hemolytic Syndromes" by Carl S. Culbertson, M.D., closed the morning session.

Adjourning to the Hotel LaSalle, the members heard J. William Wright, Sr., M.D., president of the Indiana State Medical Association, review some of the past accomplishments of medicine and

warn of the many problems that lie ahead. Pointing out that medicine has been placed in the public gaze, Doctor Wright warned that no longer can we afford to tolerate those who bring discredit upon the profession as a whole.

The afternoon program featured a paper entitled "Pardon Me, Your Skin is Showing," by James R. Webster, M.D., Professor of Dermatology, Northwestern University. William F. King, M.D., Indianapolis, gave a paper on "Progressive Steps in Geriatrics." Paul Bucy, M.D., Professor of Neurological Survey, University of Illinois, discussed "Differential Diagnosis of Spinal Cord Lesions."

The evening program featured a talk, "Merry-Go-Round of Medical Care," by Thomas A. Hendricks, secretary of the Council on Medical Services of the A.M.A. Mr. Hendricks was introduced by Kenneth L. Olson, M.D., 13th District Councilor.

Short talks were given by the guests following their introduction.

Guests introduced were: R. L. Sensenich, M.D., past president of the I.S.M.A. and the A.M.A.; J. William Wright, Sr., M.D., president Indiana State Medical Association; Alfred Ellison, M.D., immediate past-president; A. C. Yoder, M.D., Indiana's Family Physician of the Year; W. U. Kennedy, M.D., chairman of the Council; James A. Waggener, executive secretary; and O. E. Wilson, M.D., 13th District secretary-treasurer and A. S. Giordano, M.D., delegate to the A.M.A.

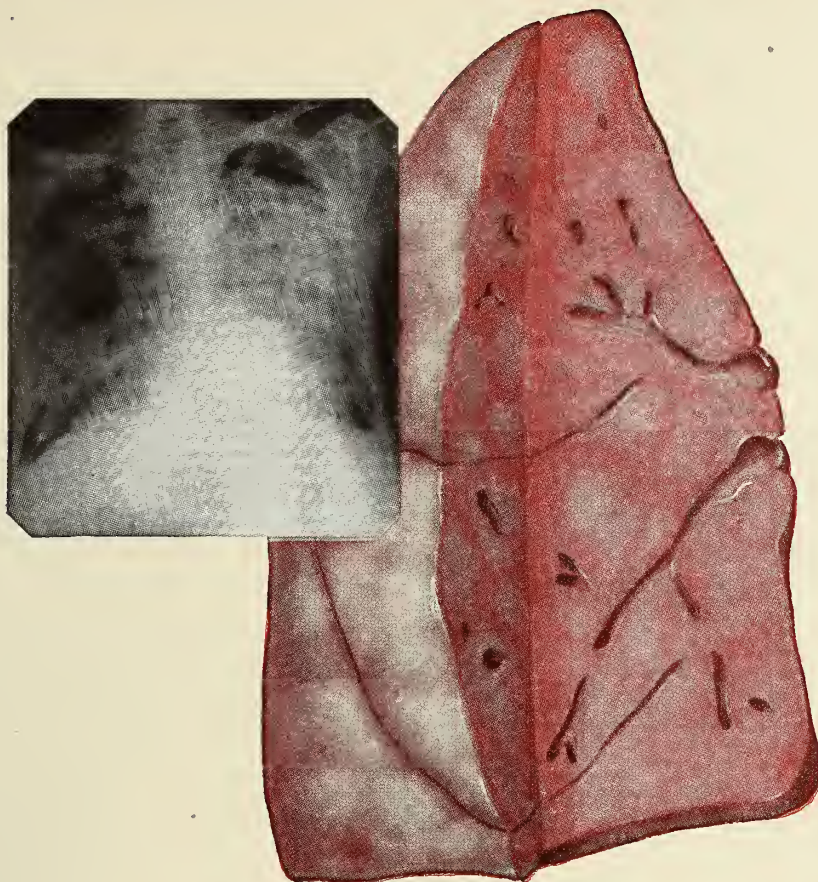
The Woman's Auxiliary elected Mrs. Daniel Stiver, of South Bend, district councilor chairman, and Mrs. Robert S. Bolin, of Elkhart, secretary.

## LOCAL SOCIETY REPORTS

Decatur County Medical Society members met at the Decatur County Memorial Hospital on November 21, when eight members were present. Representatives of Blue Cross-Blue Shield presented an outline of their program.

Fayette-Franklin County Medical Society members held a meeting at the Connersville Country Club on November 13. Dr. T. B. Noble, of Indianapolis, was the guest speaker. His subject was "Peritonitis." Fourteen members were present.

Floyd County Medical Society members held a meeting at New Albany, on November 9, when Dr. Henry Work, of Louisville, spoke on "New Aspects of Pediatric Developments." Seventeen members were in attendance.



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Potterfield, T. G., and Starkweather, G. A.:  
*J. Philadelphia General Hosp.* 2:6 (Jan.) 1951.

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Jasper-Newton County Medical Society members met at the Brook Hotel, in Brook, on November 14. Twenty-two members and auxiliary members were present. Dr. P. H. Becker, of Crown Point, talked on "Diagnostic Problems Found In Chest Diseases."

Madison County Medical Society members met at the Anderson Country Club on November 19. Dr. Roger B. Scott, of Cleveland, was the guest speaker. His subject was "Misconceptions of Uterine Carcinoma." Forty-five members were present.

Montgomery County Medical Society held a meeting at Culver Hospital, in Crawfordsville, on November 15. Twenty-one members were present to hear a tape recording on "Acute Surgical Emergencies."

Morgan County Medical Society members held a meeting at the Morgan County Memorial Hospital in Martinsville, on December 5. Election of officers for 1952 was held. Seven members were present.

Noble County Medical Society members met at Kendallville on December 4. Twelve members were present. In addition to the telephone seminar, representatives of Blue Cross-Blue Shield were on the program.

Tippecanoe County Medical Society members met at Lincoln Lodge in Lafayette, on November 13. Forty members were present to hear Doctor Corley, professor of biochemistry at Purdue, speak on "Recent Concepts of Metabolism."

Important messages are presented in the advertisements in *THE JOURNAL* each month. New products are announced from time to time, and information is presented regarding the use of products featured. Other types of ads emphasize services rendered and commodities offered that may be used in your practice, in your office, and in your home. Please tell the advertisers that you saw their ads in *THE JOURNAL* of the Indiana State Medical Association.

## *WOMAN'S AUXILIARY to the Indiana State Medical Association*

**President—Mrs. F. M. Fargher, Michigan City.**

**President-Elect—Mrs. Hubert T. Goodman, Terre Haute.**

**Corresponding Secretary—Mrs. Victor F. Kling, Michigan City.**

**Recording Secretary—Mrs. Elmer Singer, Fort Wayne.**

**Treasurer—Mrs. Robert Bolin, Elkhart.**

**Publicity—Mrs. F. M. Gastineau, Indianapolis.**

The Woman's Auxiliary to the American Medical Association held its eighth annual conference of state presidents, presidents-elect and national committee chairmen at the Hotel LaSalle, Chicago, November 14 and 15. The theme of this year's program was "Working Together For Health."

In attendance were 150 doctors' wives from all over the United States, representing their various state auxiliaries. Indiana was privileged to have four representatives, Mrs. Truman Caylor, National Finance Chairman, Mrs. Frank Gastineau, a National Director, Mrs. Francis Fargher, state president, and Mrs. Hubert Goodman, state president-elect.

This meeting is an intensive two-day workshop type to discuss all phases of the National Auxiliary program. Various state presidents participated in panel discussions on Organization, Finance, Nurse Recruitment, *To-Day's Health*, Health Days, Constitutions, Civil Defense, Legislation, Publications and Community Service. This gives each state president and president-elect a wonderful opportunity to learn what other states are doing in auxiliary work and to tell what her own state has accomplished.

Two excellent speakers were presented at the luncheon sessions, Mr. Edward H. O'Connor, Managing Director, Insurance Economic Society of America, and the Honorable Walter Judd, M.D., House of Representatives, Congress of the United States. Each spoke on Americanism and the dangers of encroaching socialism. The American Medical Association was so impressed with Dr. Judd's talk that they plan to distribute copies to all members and the auxiliary is planning to send copies to all our members.

Mrs. Caylor and Mrs. Gastineau were guests of the American Medical Association Board of Trustees at the annual dinner for all National Auxiliary Officers and Chairmen, at the close of the conference.

On Friday, November 16, many conferees took advantage of the opportunity to tour American Medical Association Headquarters Building at 535 N. Dearborn St., in Chicago.



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Norcross, B. M., *N. Y. State J. Med.* 51: 2356, Oct. 15, 1951.

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## BOOKS REVIEWED

**A TEXTBOOK OF MEDICINE**—Edited by: Russell L. Cecil, M. D., Sc.D., Professor of Clinical Medicine, Emeritus, Cornell University, New York. Robert F. Loeb, M.D., Bard Professor of Medicine, Columbia University, New York. Associate Editors: Alexander B. Gutman, M.D., Professor of Medicine, Columbia University, New York; Walsh McDermott, M.D., Associate Professor of Medicine, Cornell University, New York; Harold G. Wolff, M.D., Associate Professor of Medicine (Neur.), Cornell University, N. Y. New, 8th Edition. 1627 pages, 204 figures, 40 tables. Philadelphia & London: W. B. Saunders Co., 1951. Price \$12.00.

In approaching the review of a work of this magnitude it is obvious that no one but a retired professor could read every bit of it before the 9th edition comes off the press, but a general consideration would start with the fact that this is the 8th edition of a medical textbook which has long been respected and popular. That is a long run, and indicates the basic quality of the first edition.

The text now has two editors and three associate editors, and contains articles on 20 subjects "which have not been covered in previous editions." Besides this, 82 "new treatises on subjects previously covered" have replaced old material. In spite of this, the book has been shortened by 136 pages. The index contains 73 pages of 3 columns each, with special references to differential diagnosis, and bold-face type to indicate main discussions in the text. It seems adequate, and contains, for example, 65 items of reference under **Penicillin**, and 5 differential diagnosis references under **Peptic ulcer**.

Including the editors, there are 178 contributors, each authoritative in his field. This leads to variety in style, yet good editing has produced uniformity in presentation and format. The articles on disease entities vary in length from as long as several pages to as short as one sentence. A most helpful and time-saving device is found at the end of the book showing normal "laboratory values" of clinical importance, comprising 3 full pages in tabular form, including chemical constituents and clinical examinations of the blood, functional tests, all manner of urinary constituents, cerebrospinal fluid tests, and miscellaneous.

The modernity of this work is emphasized by the contents of chapters on diseases due to physical and chemical agents, which include aviation medicine and chronic amphetamine poisoning, as well as those chapters on adrenals, pituitary, etc. A feature of importance is the illustrations, which are of a high quality, both medically and typographically. Some are in color, and quite effective.

This work has to be seen and browsed in to be appreciated, and certainly should make an A-1 textbook for students and an excellent quick-reference book for physicians. On the sentimental side, it is a little sad that a strictly American disease, milk sickness, (now a rarity, but still possible of occurrence in the Midwest, and said to have been the cause of Nancy Hanks Lincoln's death), has been omitted, though it appeared in the 3d edition, while miliary fever, a disease never known to occur in the United States, is described.

**Whoever You Are**

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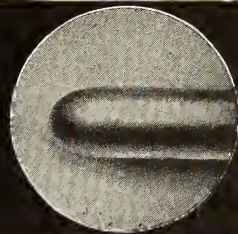
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#### MONTHLY REPORT—SEPTEMBER 1951

Disease	Sept. 1951	Aug. 1951	July 1951	Sept. 1950	Sept. 1949
Brucellosis	2	1	1	9	7
Chickenpox	20	5	33	21	8
Conjunctivitis	2	2	2	0	0
Diphtheria	6	2	6	8	55
Dysentery,					
Amoebic	1	3	0	1	0
Other	6	38	20	3	6
Encephalitis	5	0	2	3	5
Erysipelas	1	2	2	2	1
Food infection	2	3	4	3	5
Impetigo	4	7	1	2	10
Influenza	26	33	21	3	4
Infectious hepatitis	3	6	4	0	1
Malaria	8	0	0	0	10
Measles	24	21	132	18	24
Meningitis,					
Unclassified	5	5	3	3	1
Meningococcal	1	2	1	0	1
Mumps	21	24	49	21	9
Pneumonia	14	7	26	18	19
Polio myelitis	129	81	25	175	238
Rabies in animals	24	32	35	31	17
Rheumatic fever	1	0	0	3	1
Rubella	15	0	3	14	0
Scarlet fever	30	12	26	29	32
Septic sore throat	2	7	3	0	0
Tinea capitis	2	0	0	6	5
Tuberculosis,					
Pulmonary	136	141	145	150	130
Other forms	5	6	9	12	18
Typhoid fever	4	4	5	4	3
Vincent's angina	10	3	1	0	0
Whooping cough	88	96	54	123	73



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## Books

Books received are acknowledged in this column, and such acknowledgment must be regarded as a sufficient return for the courtesy of the sender. Selections will be made for more extensive review in the interests of our readers and as space permits. Books listed in this department are not available for lending. Any information concerning them will be supplied on request.

**DIABETES CONTROL.** By Edward L. Bortz, M.D., Chief of Medical Service B, The Lanhenau Hospital; Associate Professor of Medicine, Graduate School of Medicine, University of Pennsylvania; Past President of American Medical Association. 264 pages. Illustrated. Price \$3.50. Lea & Febiger, Philadelphia 6, Pa. 1951.

**TECHNICAL METHODS FOR THE TECHNICIAN.** Fourth Edition. By Anson Lee Brown, M.D., president Anson L. Brown, Inc., successor to Dr. Brown's Clinical Laboratory and Dr. Brown's School for Technicians, Columbus, Ohio. 784 pages. Price \$10.00. Published by the author, 41 S. Grant Ave., Columbus, O. 1950-51. Fourth edition is not copyrighted.

**PEPTIC ULCER — Clinical Aspects-Diagnosis-Management.** By David J. Sandweiss, M.D., Associate Attending Physician, Division of Internal Medicine, Harper Hospital, Detroit, Michigan. Published under the auspices of the American Gastroenterological Association. 790 pages with 164 figures. Price \$15.00. W. B. Saunders Company, Philadelphia 5, Pa. 1951.

**FROM A DOCTOR'S HEART.** By Eugene F. Snyder, M.D., Chicopee Falls, Mass., where he has practiced medicine since 1940, having located there after leaving Czechoslovakia where he spent nineteen years after being forced out of Russia. A personal account of his own recovery from coronary thrombosis. 251 pages. Price \$3.75. Philosophical Library, 15 E. 40th Street, New York 16, N. Y. 1951.

**STATISTICS FOR MEDICAL STUDENTS** and Investigators in the Clinical and Biological Sciences. By Frederick J. Moore, M.D., Associate Professor of Experimental Medicine, Frank B. Cramer, B.A., Research Fellow, and Robert G. Knowles, M.S., Research Associate. Department of Experimental Medicine, University of Southern California School of Medicine. 113 pages, 11 figures and 16 tables. The Blakiston Company, Philadelphia 3, New York 22, 1951.

**AN ATLAS OF NORMAL RADIOGRAPHIC ANATOMY.** By Isadore Meschan, M.D., Professor and Head of the Department of Radiology, University of Arkansas School of Medicine. With the assistance of R. M. F. Tarrer-Meschan, M.B., B.S. (Melbourne, Australia). 593 pages. 1044 illustrations and 362 figures. Price \$15.00. W. B. Saunders Company, 218 West Washington Square, Philadelphia 5, Pa. 1951.



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### CARDIAC ARREST UNDER ANESTHESIA\*

WILLIAM R. STILWELL, M.D.† &  
LILLIAN B. MUELLER, M.D.‡

*Indianapolis*

CARDIAC arrest is, without doubt, the most serious emergency that can arise in the operating room. It has been stated that the emergency will confront almost every surgeon at least once during his career. Ruzicka and Nicholson<sup>1</sup> state that a busy surgical clinic may expect at least two cases a year. Lahey and Ruzicka<sup>2</sup> have analyzed data from a large number of cases from five teaching hospitals and give an expected mortality occurring during operation and anesthesia from all causes of 1:1000. The same authors again give an incidence of one or two cases of cardiac arrest each year in hospitals with active surgical services. They state that the exact incidence of cardiac arrest is, however, unknown.

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\* Presented by Doctor Mueller before the Vanderburgh County Medical Society, at Evansville, September 11, 1951.

Aided by a grant from the Charles J. Wolf Foundation for Medical Research.

† Senior Resident in Anesthesiology at Indianapolis General Hospital.

‡ Director of Department of Anesthesiology at Indianapolis General Hospital.

The emergency is one which calls for the immediate institution of a preconceived and well coordinated program of therapy if the patient is to recover and be able to lead a normal existence. Such a therapeutic program requires the absolute cooperation of all members of the surgical team, each of whom must know what part he has to play in the treatment and be prepared to carry out his part without delay or hesitation. Lahey and Ruzicka<sup>2</sup> state that in having some experience with cases of cardiac arrest, they have observed how disquieting such cases can be and how difficult it is for surgeon, anesthesiologist, and particularly for other operating room personnel, to act and function effectively without panic and undue loss of time. We feel strongly that if such a patient is to survive, this panic and loss of time must be avoided and that all members of the surgical team must work together as a unit to restore adequate cardio-respiratory function to the patient. The purpose of this paper is to present a few of the theories regarding the etiology of the condition and to present a program of therapy.

### *Etiology*

Cardiac arrest can occur at any time and in any patient, according to Lahey and Ruzicka.<sup>2</sup> Indeed, the literature contains many reports of cardiac arrest under all types of anesthesia, in all ages of patients and during all types of surgery. Ruzicka<sup>3</sup> states that the type of operation is of no assistance in anticipating or preventing sudden cardiac arrest since it may occur during any operative procedure and may also occur with any anesthetic agent or combination of agents, including spinal anesthesia. The incidence of cases is certainly more frequent than it was in the past. This may be due to the greater awareness of the diagnosis today and of the presence of better aids to confirm the diagnosis, or it may be due to the fact that the great progress in modern surgery has increased the risk to the patient. Certainly intrathoracic and highly specialized abdominal surgery, as well as neurological surgery, have increased this risk. Likewise, the fact that many of these operative procedures are much more common in the older age group of patients may well play a part in the greater incidence of the condition seen today. Despite these facts, surgery upon the older age groups, with its attendant risks, is an established fact today. For this reason, it behooves both the surgeon and the anesthesiologist to be absolutely sure that the patient is in the best possible physical condition before any anesthetic or surgical procedure is considered.

Lampson et al<sup>4</sup> state that experience, experimentally with animals and clinically with patients, has shown that sudden circulatory arrest may be due either to cardiac standstill or to ventricular fibrillation. In cardiac standstill or asystole there is complete cessation of contraction of the myocardium. In fibrillation the coordinated contraction of the ventricles is replaced by rapid irregular twitchings of the myocardium. Its persistence, as well as that of asystole, is incompatible with life because such twitchings are ineffectual in expelling blood from the chambers of the heart. The gross appearance of the heart in fibrillation has led to the descriptive term, "bag of worms," being applied to it.

It should be pointed out that unless the chest is open, the diagnosis of which type of arrest occurred is impossible unless the electrocardiograph is attached to the patient and in operation when the arrest occurs. While the exact type of

arrest is not too important in the early course of therapy, it may be extremely important in later stages when drug therapy is resorted to. In fact, Johnson and Kirby<sup>5</sup> maintain that under conditions of cardiac arrest, direct access to the heart either transthoracically or transperitoneally becomes a diagnostic procedure.

There are probably few instances in which the cause of cardiac arrest may be definitely ascertained. However, several factors of possible etiological significance are known. Any one or all of these factors may play a part in precipitating this emergency. There are, undoubtedly, other factors about which little is known that play a part in cardiac arrest. Some of these theories concerning the factors will now be discussed.

Anesthesia, both generally and specifically, must be considered as a cause. Fauteux and Levy<sup>6</sup> state that it should be emphasized that in the reported cases this calamity occurred most often during light anesthesia in either the phase of induction or recovery, when the myocardium is known to be more irritable than normally. Observation at the Indianapolis General Hospital in the past eighteen months bears out this statement. One of our cases occurred during the induction of a cyclopropane anesthetic. Another was seen during the recovery phase of an open drop ether anesthetic where the child had received no ether for at least five minutes prior to the arrest. A third case occurred during the recovery period of a Pentothal anesthetic and three cases were noted during the recovery period of Pentothal, nitrous oxide and curare anesthesia, two of which occurred during the completion of the surgery and one immediately after completion.

It is possible, however, for cardiac arrest to occur during the deeper planes of anesthesia when respiratory paralysis with its resultant anoxia occurs. Since the myocardium is the second most susceptible tissue of the body to anoxia, it rapidly becomes hyperirritable in this situation and arrest can occur. This can be easily prevented, however, by keeping the stage of anesthesia from progressing to the point of respiratory paralysis. If it should progress that deeply, however, manual compression of the re-breathing bag will maintain artificial respiratory movements until the anesthesia lightens sufficiently for the respiratory mechanism again to take over. Robbins<sup>7</sup> and Meek<sup>8</sup> both point out



the ability of chloroform, cyclopropane and ethyl chloride to sensitize the myocardium to the action of epinephrine. Goodman and Gilman<sup>9</sup> state that chloroform has the greatest activity of these three drugs as a myocardial depressant. Robbins<sup>7</sup> also maintains that hypoxia and excitement will increase the content of epinephrine in the circulating blood. Burstein and Rovenstine<sup>10</sup> have shown that intravenous barbiturates and cyclopropane have a parasympathetic effect on the heart with a resulting depression of the myocardium.

Hemorrhage must also be considered as a cause of cardiac arrest. The sudden loss of a large quantity of blood from the circulatory system is poorly tolerated by any patient but particularly by those undergoing surgery, probably because there is always a certain unavoidable loss of blood during any operation. In the patient with a sudden loss of a large quantity of blood, the first result is hypotension, if not immediate shock, with the rapid onset of so-called anemic anoxia in which the circulating blood is of insufficient amount to carry adequate oxygen to the tissues. Here again the susceptibility of myocardial tissue to anoxia rapidly leads to hyperexcitability of the myocardium.

Respiratory paralysis with its resultant anoxia is another cause of cardiac arrest. The pathogenesis of this mechanism has been dealt with under the anesthetic causes of cardiac arrest. It is sufficient to reiterate here that respiratory paralysis resulting from too deep a plane of anesthesia can be prevented and, should it inadvertently occur, can be effectively treated until the normal respiratory mechanisms can again take over the maintenance of respiration. Pure oxygen and artificial respiration, preferably using the rebreathing bag, are of aid here.

With the advent of curare and curare-like preparations, respiratory paralysis is seen more frequently, even though the plane of anesthesia is not deep enough to cause paralysis. In using curare, careful observation of the patient's respiratory movements by the anesthesiologist is mandatory and, should respiratory paralysis result, artificial respiration will in every case maintain the patient until the curare action has worn off and spontaneous respiratory movements are resumed.

Certainly the most serious result of respiratory failure is anoxia and since the two are closely

related, anoxia will be discussed here. Nervous and cardiac tissue are quickly damaged by anoxia. The cells of the cerebral cortex are the first to be damaged by oxygen lack, while the lower brain stem, including the vasomotor and respiratory centers, are damaged somewhat later. MacLeod<sup>11</sup> states that in patients with normal hearts, death due to anoxia is from failure of the respiratory center, and shortly thereafter there is cessation of cardiac action. Anoxia depresses the myocardium directly and will lead to cardiac standstill unless promptly corrected, for unlike skeletal muscle it cannot function anaerobically even for short periods. Beck and Mautz<sup>12</sup> state that ischemic zones of heart muscle are often hyperirritable and they refer to such zones as trigger zones. These ischemic zones are believed responsible for the onset of ventricular fibrillation in patients with coronary artery disease. Anoxia may prove further harmful by initiating the release of epinephrine which may increase the tendency toward ventricular fibrillation, especially with certain anesthetic agents.

Reid and Brace<sup>13</sup> maintain that vagal stimulation may inhibit cardiac activity. It is a well-known fact that the vagi carry cardio-inhibitory fibers. According to Best and Taylor,<sup>14</sup> the vagi convey fibers from the cardio-inhibitory center in the medulla near the dorsal nucleus of the vagus situated in the floor of the fourth ventricle, and vagal stimulation, especially of the left vagus, can cause ventricular standstill.

Many published reports suggest the action of a vagovagal reflex in producing cardiac arrest. Burstein,<sup>15</sup> for instance, reported circulatory reactions during thoracic surgery which he credited to such a reflex. He and his group reported disturbances from pericardial manipulation, endotracheal intubation, pleural incision, scraping of the periosteum of the ribs, bronchial and hilar manipulation, and positional changes during anesthesia. This same group of workers states that the vagi are extremely sensitive to stimulation high in the chest and even a mild stimulus may produce reflex asystole. This reflex type of cardiac arrest will respond promptly to the proper therapy which consists primarily of atropine medication.

A somewhat similar mechanism is seen in the stimulation of the carotid sinus. Downs<sup>16</sup> explains this phenomenon as a sensitization of the carotid sinus with a resultant reaction to the

stimulation that ends with cardiac inhibition. Atropine premedication will aid in preventing this complication by depressing the parasympathetic innervation.

Pneumothorax and asphyxia have been mentioned as possible causes of cardiac arrest. The mechanism here is the same as that in respiratory paralysis with an anoxic anoxia resulting in increased myocardial sensitivity.

Idiosyncrasy or sensitivity to the anesthetic agent may play a role in cardiac arrest. This is seen most frequently when cardiac arrest occurs under spinal or local anesthesia. A thorough allergic history and adequate premedication, especially with the barbiturates, may prevent this occurrence.

Finally, the pre-existence of cardiac disease may subject the patient to cardiac arrhythmias, congestive failure and cardiac arrest. Such patients tolerate hypoxia very poorly and the successful resuscitation of such a patient is very unlikely.

This list of possible causes is probably not complete, but it will furnish some idea as to the wide range of etiological theories and will furnish some basis for further discussion, particularly of the diagnosis and treatment.

That the surgeon is not the first to make a diagnosis of cardiac arrest is the contention of Lahey and Ruzicka.<sup>17</sup> They say:

"The surgeon is usually not the first to make the diagnosis in this complication unless the operation he is doing is of such a character that he happens to have an artery under direct vision and notes cessation of pulsation in it, or unless the chest is open and the heart and great vessels are visible. The anesthesiologist is frequently the first to become aware of sudden cardiac arrest, and it is he who, in the great majority of cases, will need to notify the surgeon of the need for immediate action. He must notify the surgeon as soon as pulse and blood pressure disappear. If he even suspects that there has been an arrest, the surgeon must be asked to check for arterial pulsation. False alarms will inevitably occur but must be understandingly tolerated. The short time during which treatment, to be effective, must be applied means that the anesthesiologist and the surgeon cannot waste time in useless checking but must be ready for instant decision and rapid institution of emergency measures."

The surgeon is, by custom, in charge of the surgical team. However, in an emergency of this caliber, our department feels that the surgeon

must be prepared to act as soon as the anesthesiologist states that such action is necessary.

Time is at a premium in this condition and there should be no delay in starting treatment once the diagnosis has been made. It has been shown that those patients who recovered following a cardiac arrest have been those in whom there was no delay present before starting treatment. Weinberger, Gibbon and Gibbon<sup>18</sup> have shown that treatment must begin within three and a half minutes of cessation of the circulation of the blood. They have shown that interruption of the circulation to the brain for three and one-half minutes resulted in permanent changes in psychic behavior and that interruption for eight and three-quarter minutes was incompatible with life for more than a few hours.

It may thus be seen that the most important steps to be taken in such an emergency are the immediate diagnosis without useless loss of time and the rapid institution of therapy which will now be discussed.

### *Therapy*

Equipment for the management of these cases consisting of instruments, syringes, needles and drugs should be kept sterile and ready for use in a readily available location in each operating room. In the Indianapolis General Hospital surgery, a sterile tray containing those instruments necessary for a thoracotomy, syringes, needles and drugs, is kept available in the surgery at all times. We feel that without this foresightedness, the time loss and the inevitable confusion will result in restoration of cardiac activity too late to restore full and normal cerebration to the patient.

Immediately after the diagnosis is made, the early stages of treatment must be started. Each member of the surgical team has a definite role to play and each is expected to do his part without urging. The patient should be placed in fifteen degrees of Trendelenburg's position. If a patent airway is not already present, this must be established at once by the anesthesiologist. This is best accomplished by the insertion of an endotracheal tube. Artificial respiration by means of manual compression of the rebreathing bag and using 100 percent oxygen should be started and carried out at a rate of from sixteen to twenty per minute. Aspiration of the tracheobronchial tree should be done if secretions are interfering



with the maintenance of an open airway. At the same time, and this is the all important step, the surgeon must begin immediate cardiac massage. If the chest is open, this can be easily instituted. If the abdomen is open, an attempt at massage through the diaphragm can be carried out, but if a peripheral pulse is not present after a period of not more than sixty seconds, this method should be abandoned and the heart approached directly, either through the left side of the diaphragm or through a new intercostal approach. Lampson<sup>4</sup> and his co-workers recommend the direct anterior intercostal approach, entering the chest through the fourth or fifth interspace. This allows the index and middle fingers of the left hand to be placed directly against the heart, so that effective intermittent compression of the ventricle against the sternum can be maintained. On the other hand, however, Johnson and Kirby<sup>5</sup> feel that the best results may be obtained with one hand behind and one in front of the heart or with the thumb in front and the remaining fingers behind the heart. The method used is probably the least important consideration but every surgeon should decide on one and practice its use.

The rate at which this massage should be carried out is ideally about one hundred and twenty per minute. However, it has been found that unless several surgeons are present to relieve one another, a rate of from forty to sixty beats per minute is all that a single surgeon can maintain for any period of time without becoming rapidly fatigued. This massage, according to Ruzicka,<sup>3</sup> must be carried out for three to five minutes, and longer if necessary. Gunn<sup>19</sup> maintains that cardiac massage is not a question of indifference but that attention to detail is important. He, as well as many other authors, feels that the compression should be gradual and the relaxation abrupt, with the rate of compression, at most, only half the normal rate. The massage must be interrupted at regular short intervals for a few seconds to allow spontaneous beats to develop. He feels that the slower rate is better to allow the ventricles time to fill adequately. He further reasons that the slower rate is better because one is attempting to elicit a subnormal rate of beat, namely, that rate which will allow the arrested heart to resume beating again. He further emphasizes that massage is used to stimulate the heart and maintain circulation, but that the most important thing is stimulation of the heart.

In the excitement of the moment, mechanical stimulation can be overdone. One should stop frequently and watch for the first feeble heart beats and if these do not improve, help must be supplied at intervals.

If the ventricles are fibrillating, the fibrillation must be stopped before normal rhythm can be resumed. It is here that electrical stimulation and/or drug therapy will be of use. Drug therapy will be discussed later. Electrical stimulation can be accomplished by several means. A simple method, but one which is not to be recommended except in an extreme emergency, is merely the utilization of the cut ends of an electric cord with one or two brief shocks being applied to the myocardium. A far better method, however, is the use of the defibrillator which was developed by Beck at Western Reserve. However, this apparatus is not available in all hospitals at the present time. A somewhat simplified form of the defibrillator can be easily prepared and kept in surgery at all times. In brief, it consists of two round electrodes about two and one-half inches in diameter, which are padded with gauze soaked in saline solution. These are applied to the anterior and posterior surfaces of the heart and 1.0 and 1.5 amperes of alternating current is applied for 0.1 to 0.5 seconds. Beck feels that such a stimulus will usually bring the muscle to a standstill and a normal rhythm may then be resumed. If this fails, drug therapy must be resorted to, but most cases of fibrillation can be stopped by such a technique. Even if the heart refuses to resume a normal rhythm after the fibrillation is stopped, manual compression may be continued until it does so.

### *Drug Therapy*

Drug therapy has already been mentioned briefly. In fibrillating hearts, procaine has been found effective in stopping the abnormal rhythm. There seems to be almost as many methods of use for this drug as there are reports of its use in the literature. Two of these methods will be discussed here. The first is that of Beck<sup>20</sup> and his group. He recommends the injection of five cubic centimeters of 2 percent procaine into the cavity of the right heart, meanwhile continuing massage. He also feels that 5 percent procaine or 10 percent Metycaine applied to the ventricles may aid in stopping the fibrillation. The action of the depressant drugs, he feels, is due to an

elevation of the threshold of the cardiac musculature to incoming stimuli with a resultant rendering ineffective of the minimal stimulus which is causing the fibrillation. The second method of administering procaine is that of Ruzicka and Nicholson.<sup>1</sup> In their clinic, a kit consisting of a long cardiac needle, two five cc. syringes, two twenty gauge needles, one ampoule of 1:1000 epinephrine, and two ampoules of 1 percent procaine (6 cc. each) are kept sterile and ready for use in the operating room. When arrest occurs, the cardiac needle without an attached syringe is immediately inserted by the surgeon. They feel that this maneuver will tell whether the heart is actually beating or not, and will, in rare instances, provide the necessary stimulus to cause the heart to resume beating. Meanwhile, an operating room assistant is drawing up four and three-quarters cubic centimeters of 1 percent procaine and one-quarter cubic centimeters of 1:1000 epinephrine. This is given to the surgeon who injects it while the second syringe is prepared in a similar manner. If after three to five minutes there is no response, these authors then feel that it is advisable to make the second injection. Following this, a continuous drip of procaine may be started but they feel that the epinephrine should never be repeated. They emphasize that no time should be lost in attempting this therapy if the instruments and drugs are not sterile and readily available and that the drug therapy should be given concomitantly with cardiac massage.

Epinephrine can be used on hearts with cardiac standstill or asystole. However, because of its tendency to produce ventricular fibrillation, it must be used with caution. Probably the largest dose that can safely be used is one-half cubic centimeter of a 1:1000 solution. When it is combined with procaine, the incidence of fibrillation seems to be lower and it would seem that it is much safer to use epinephrine only in combination with procaine, rather than alone.

Pronestyl or procaine amide has been found to be useful in the treatment of fibrillation although its use remains somewhat controversial at present. It is longer acting than procaine and has no central stimulatory effects. Its use, as discussed in "The Treatment of Ventricular Arrhythmias,"<sup>21</sup> has produced satisfactory results in several groups of patients. The recommended dosage for patients under anesthesia is one to

five cubic centimeters (100 to 500 milligrams) intravenously. It is strongly recommended that no more than two cubic centimeters or two hundred milligrams be given per minute.

Drug therapy definitely has its role in this condition, but only in the latter stages of treatment after establishment of the diagnosis and the institution of a patent airway and cardiac massage have been begun.

### *Intravenous Therapy*

While the anesthesiologist and surgeon are attending to the artificial respiration and cardiac massage and even before drug therapy is considered, a third member of the team should be responsible for intravenous therapy. In cases where there has been hemorrhage, sufficient blood must be given to more than cover that which has been lost. Intravenous fluids must be started or kept running in order to have a route for intravenous drug therapy.

The method of arterial transfusion in the treatment of cardiac arrest and profound shock must be mentioned, also. Interest in the early work in this field has only recently been renewed. Ciliberti and Dickler<sup>22</sup> report on a resuscitation by such a method in a recent journal. The authors themselves have seen two patients at the Indianapolis General Hospital who have made almost miraculously unbelievable recoveries after intra-arterial transfusions. Such a procedure should be kept in mind in an emergency such as this.

### *Summary*

An attempt has been made to present what is, in all probability, the most drastic emergency that can be seen in the operating room; to discuss some of its etiological factors, and to present a plan which the department of anesthesiology of this hospital feels will allow a good percentage of patients undergoing cardiac arrest to be successfully restored to a normal existence. While it is sincerely hoped that no such cases will be seen by anyone, it is best to keep in mind that they can and do occur at any time.

It is strongly felt that immediate institution of therapy, when it is called for, by each member of the surgical team without any delay, hesitation or failure to realize his part in the program is essential in restoring these patients to a normal



life postoperatively. Briefly, these steps are as follows:

1. Artificial respiration with 100 percent oxygen and maintenance of an open airway must be the responsibility of the anesthesiologist.

2. Immediate cardiac massage by one of three routes must be the responsibility of the surgeon. These routes include (1) transperitoneal subdiaphragmatic, (2) transperitoneal transdiaphragmatic, and (3) transthoracic.

3. General supportive therapy, including intravenous administration of fluids and the establishment of fifteen degrees of Trendelenburg's position, must be the responsibility of a third member of the team. It may also be this man's responsibility to attend to intra-arterial transfusion.

4. The use of drug therapy as outlined above is primarily the responsibility of the surgeon, but the preparation of such materials as may be needed is the responsibility of the nursing staff.

If these steps are kept in mind, each member of the surgical team will know them all and will be aware of which are his own responsibility. Furthermore, if each surgeon, regardless of what special branch of surgery he practices, will memorize the three approaches to the heart and will be prepared to begin massage immediately after the anesthesiologist states that it is necessary, it should be possible to resuscitate the greatest number of cardiac arrests which any one of us may see in the future.

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# XANTHOMA TUBEROSUM

## Report of a Case

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**X**ANTHOMA TUBEROSUM is one of that group of diseases characterized by a disturbance of lipid metabolism and manifested by typical lesions of the skin and hypercholesterolemia. These skin lesions are the result of deposition of fatty substances in the cells and between the cells of the skin. They are most commonly located on the extensor surfaces of the elbows, hips, and knees. Xanthoma tuberosum is frequently associated with cardiovascular disease and occasionally with liver disease.<sup>1</sup>

This patient, L. DeL., a 19-year-old white male, was first seen at the Out-Patient Dermatology Clinic at Lackland Air Force Base Hospital. He complained of nodular growths on his right elbow and both knees. These growths were asymptomatic and the only reason for coming to the clinic was a fear that the growths might be cancerous. These lesions had been present for about two years with no change in size, number, or consistency within the past twelve months. He had no history of other skin disease nor had these lesions appeared elsewhere on his body. He presented no other complaints. He was questioned closely, but no history of angina pectoris could be elicited. Past history, except for an uncomplicated appendectomy in 1944, was negative. There was no family history of coronary artery disease. No members of his family have been examined by us, but a ten-year-old brother was reported to have one nodule on the extensor surface of the right knee similar in appearance to those of this patient.

### *Physical Examination:*

This patient was well nourished and well developed, was 5' 10" tall, and weighed 180 pounds.

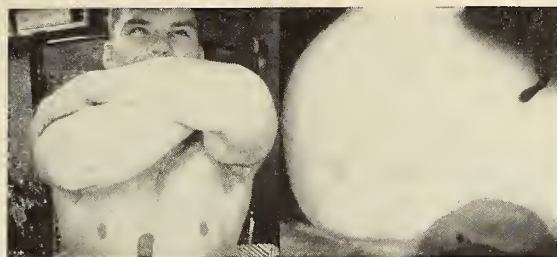
Pulse rate was 72; blood pressure was 110/62. Examination of the optic fundus and retina was normal; there was no evidence of vascular disease. No evidence of cholesteatoma in the ear was seen. The oropharynx was normal; no lesions of oral mucous membranes were present. There was no indication of peripheral arteriosclerotic disease. Except for the skin lesions, the general physical examination and neurological examinations were negative. The skin lesions were small, discrete, well margined, and freely movable nodules about 1 to 1.5 cm. in diameter. They were a mottled dark red and yellow in color and were present in groups of two or three on the extensor surfaces of the right elbow and both knees.

### *Laboratory Data:*

The urinary specific gravity was 1017; albumin and sugar tests were negative; and microscopic examination was normal. The red blood cell count was 4,328,000; hemoglobin was 15 gms. percent; and the hematocrit was 45. The total white count was 7,450 with 76 percent polymorphonuclear cells, 20 percent lymphocytes, and 4 percent monocytes. Three basal metabolic rate determinations were made on successive days with the result of minus 9, minus 11, and minus 8. Fasting blood sugar was 108 mgm. percent. The glucose tolerance curve was normal. A thymol turbidity test was done on two occasions and was reported as 10.0 units and 9.8 units. A Bromsulfalein test (5 mgm. test) was normal, with no dye retention after 30 minutes. Cephalin flocculation in 24 hours and in 48 hours was negative. Total serum protein was 7.4 gm. percent, with 4.7 gm. percent of albumin and 2.7



Figures 1 and 2



Clinical photo showing skin manifestations of this disease as they appeared on the extensor surface of the right elbow.

Clinical photo showing skin manifestation of xanthoma tuberosum as they appeared on the right elbow

gm. percent of globulin present. Serum alkaline phosphatase was 5.5 units; prothrombin time was 15.8 seconds. (Control time 15.8 seconds.) A 24 hour urine specimen contained no bile and a total of 2.5 mgm. of urinobilinogen. A specimen of blood was allowed to clot and after retraction it was noted that the serum was clear and not milky. Total serum cholesterol and cholesterol esters were 1025 mgm. percent (normal 150-260 mgm. percent) and 315 mgm. percent (normal 70-75 percent of total cholesterol), respectively. Total serum lipid was 2490 mgm. percent (400-700 mgm. percent), and the total fatty acid level was 1465 mgm. percent (190-450 mgm. percent). Serum lipid phosphorus level was 7 mgm. percent (6-10 mgm. percent). Roentgenograms of the skull, long bones of the extremities, and hands and feet were normal. A P-A view of the

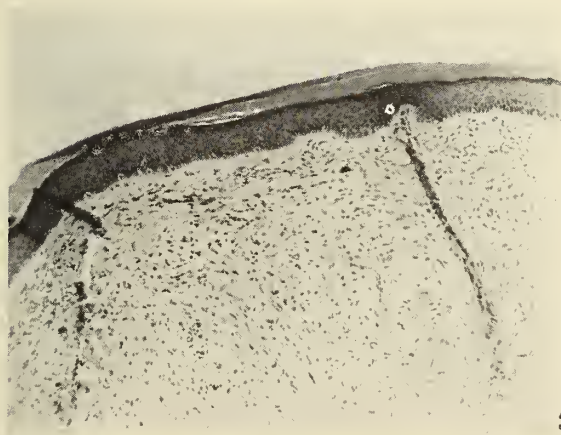
chest was normal and a gallbladder series using Priodax was normal. Two electrocardiograms, one with a Master's step test, were done; and were considered to be within normal limits.

One of the nodules was removed from the extensor surface of the left knee for microscopic study. In the corium of the skin was a collection of foamy cells with irregular nuclei. There was no definite capsule. Some of the cells were quite large and had several nuclei, usually in the periphery. These foamy cells were arranged in clusters and strands coursing irregularly in the collagenous tissue of the dermis. The epithelium showed no change.

### Discussion:

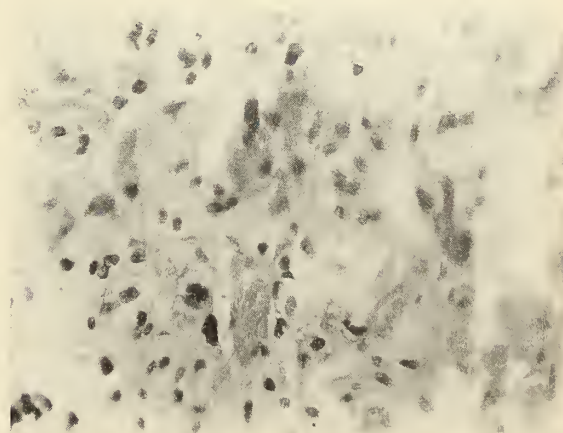
This case of xanthoma tuberosum in an apparently healthy, young, white male is presented because of the general interest in this uncommon entity and because of the special interest to physicians doing induction physical examinations. This disease is one of the group of essential xanthomatoses of the hypercholesterolemic type and is the second most common<sup>2</sup> of the lipid diseases manifested by skin lesions (xanthelasma is the most common). There is apparently no predilection for either sex or any racial group, and it is usually found in young adults. This type of lipid metabolic disturbance is an inherited defect,<sup>3</sup> specifically of cholesterol metabolism. However, there is no agreement as to the mechanism of inheritance. The complications of this disease are cardiovascular and hepatic pathological processes. The heart is involved in 40

Figure 3



Photomicrograph showing the arrangement of these large foamy cells in irregular clusters and strands in the collagenous tissue of the dermis. (Biopsy of tumor from the extensor surface of the left knee.)

Figure 4



Photomicrograph showing multinuclear, foamy cells. (Biopsy of tumor from the extensor surface of the left knee.)

percent to 50 percent of cases;<sup>2</sup> and hepato-cellular damage is present in 15 percent of the cases.<sup>4</sup>

There is no demonstrable evidence in this patient of coronary artery or other vascular disease, but it was considered that this patient had evidence of hepato-cellular damage which may terminate in xanthomatous biliary cirrhosis. The thymol turbidity was elevated and there was a disproportion between free cholesterol and the cholesterol esters. The glucose tolerance curve was borderline.

A case of xanthoma tuberosum in an otherwise

normal adult white male has been presented. There was minimal evidence of associated involvement of the liver, but no demonstrable evidence of vascular disease.

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### AMERICAN LEGION PLEDGES SUPPORT TO MEDICAL PROFESSION

**I**N A SURPRISE appearance before the House of Delegates of the American Medical Association at the Clinical Session in Los Angeles, Donald R. Wilson, Clarksburg, West Virginia, National Commander of the Legion, said "Three million members of the Legion stand shoulder to shoulder with you, as doctors, in your battle to overcome the encroaching forces of socialized medicine.

"No organization," he said, "is more determined to have the genius of the American Doctor unshackled by any form of socialism of American Medicine."

Attorney Wilson said, "It is our firm and unalterable belief that the American doctor, when left to his own inspired resources, will provide the basic answers to the problem of medical care which face not only the American veteran, but also the American people at large."

He was given a great ovation by the more than

200 members of the House of Delegates, which is the policy-making body of the AMA.

Mr. Wilson said that the American Medical profession "must be the watchdog of American Health and no health program, wherever it may exist, is too small or too inconsequential to receive absorbed attention of the medical profession.

"Your profession must avoid at all costs being thrown in a defensive position on this subject. The American people look to you for leadership, they look to you for planning, and look to you for results. If you publicly discharge your functions the American people will not buy any bureaucratic controlled scheme for the enslavement of American medicine.

"You may depend on us to carry our full share of what is primarily your battle. We shall do it not only for your good but also for the good of the American people. We see and understand your problem and are prepared to render whatever service we can."





# PSITTACOSIS

## A Report of Three Cases

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*P* SITTACOSIS (ornithosis) is a highly infectious disease caused by a filtrable virus which is endemic in birds and is readily transmissible to man. Most infections in man are acquired from members of the parrot family. Chickens, pigeons, fulmars or petrels, and canaries have also frequently transmitted the disease to man. However, since psittacosis is acquired by droplets from nasal secretions, as well as by handling dead or sick birds or their cages, there have been human case-to-case infections recorded.

The incubation period of psittacosis is seven to fifteen days. The initial symptoms are fever, malaise, headache, and anorexia. The temperature is usually remittent and remains elevated for two to three weeks. There is a nonproductive cough and x-ray evidence of a patchy consolidation beginning at the hilum, but usually no physical signs of pneumonia. The leukocyte count and respiratory rate remain normal and the pulse remains slow in relation to the temperature. Before the development of aureomycin and terramycin the mortality rate was about 20 percent. Now it is considerably lower.

As no cases of psittacosis have previously been reported to the Indiana State Board of Health it was thought a report of the three following cases might be timely.

### *Case Reports*

CASE 1.—E. H., a 67-year-old white housewife, was first seen on June 8, 1951, with the complaints of generalized aching and nausea and vomiting for 24 hours. Her temperature was 100.6° F. Physical examination showed no abnormal findings. No definite diagnosis was made, and bed rest, aspirin, and aluminum hydroxide gel were prescribed.

On June 12, 1951, the patient was visited again and found to have a temperature of 101° F. Her only complaints were a hacking cough and weakness. Physical examination again showed no abnormal findings. As she had been away from home for several months visiting friends and relatives, she was questioned as to possible exposure to various diseases and to the water and milk she had consumed. No fruitful information was gained. The patient was not particularly concerned over the continuation of her fever. Aspirin was continued as needed for aching.

On June 17 she was admitted to the Witham Memorial Hospital with a temperature of 102.2° F and with weakness as the only complaint. Physical examination again was essentially normal. Urinalysis (voided specimen) on June 18 was albumin 2+, sugar negative, W.B.C. rare, R.B.C. negative, epithelial cells rare, and casts negative. A blood count on the same date showed R.B.C. 5,800,000, W.B.C. 5,800, Hb 15.3 Gm., polymorphonuclear cells 70 percent, and lymphocytes 30 percent. Blood drawn for agglutination on that date and reported on June 19 was negative for typhoid, paratyphoid A, paratyphoid B, and undulant fever. Blood culture drawn on that day was later also reported as negative.

On June 20 her temperature was still elevated to 101.8° F (see Figure 1) and the following report of an x-ray of her chest (Figure 2) was received: "The right lung is clear. There are a number of areas of increased density in the left lung involving the midportion of the lung laterally and the upper lobe. There is some elevation of the left side of the diaphragm. The appearance suggests an inflammatory process with considerable loss of aeration in the left lung. The heart shadow is at the upper limits of nor-

Figure 1

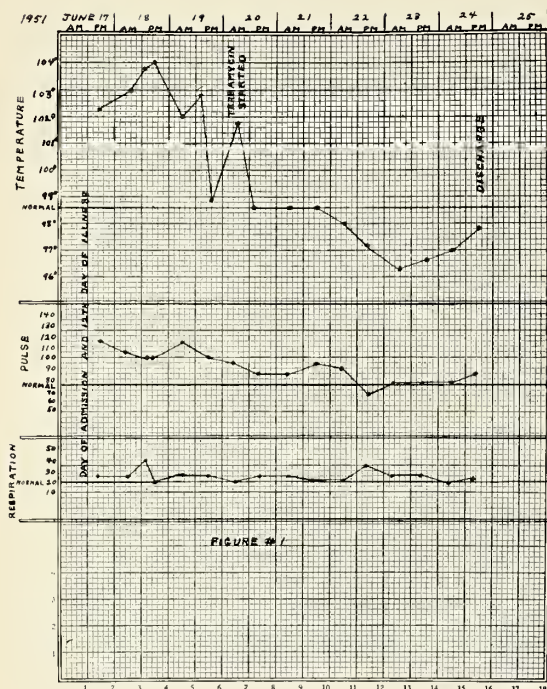
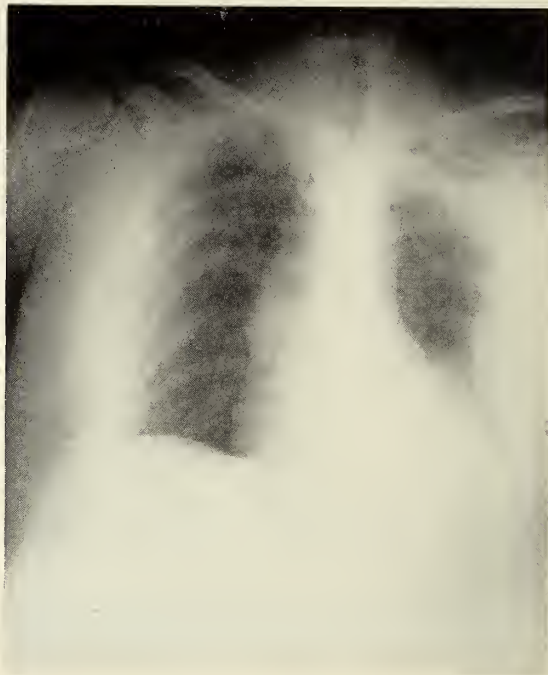


Figure 2



mal in size, and the aorta is calcified. CONCLUSION: Inflammatory process in the left lung, probably pneumonia. Signed—Dr. C. A. Stayton, Jr.”

On closer questioning she stated that she had forgotten to mention previously that on May 27 she, with four others, had driven to Illinois where they had visited a parakeet aviary. She also stated that the owner of the aviary and his wife had both been ill with “virus pneumonia,” in fact, the wife had been hospitalized, and that they still felt badly at the time of the visit.

With this information and the clinical picture of psittacosis, a provisional diagnosis of psittacosis was made, blood drawn for complement fixation for psittacosis, and the patient started on terramycin, 500 milligrams every 6 hours. Her temperature fell to 98.6° F that evening and remained normal.

The report on complement fixation test for psittacosis done by Dr. Sherman A. Minton, Jr., of the Department of Microbiology of the Indiana University School of Medicine, which was received on June 23, was positive in dilution of 1:8.

The terramycin was discontinued and the patient was dismissed from the hospital with no complaints other than weakness on June 24.

On July 27 (the patient had been away from home convalescing) more blood was drawn for confirmation. One specimen was reported by Doctor Minton as complete fixation with psittacosis antigen at 1:32 dilution and partial fixation at 1:128 dilution.

A second specimen sent to Communicable Disease Center, Virus and Rickettsia Section, Public Health Service, Montgomery, Alabama, was reported as positive for psittacosis in the dilution of 1:32.

At that time the patient felt well and had no complaints.

CASE 2.—G. D., a 57-year-old white housewife, was first seen on June 7, 1951, with the complaints of generalized aching, chills, fever and headache for several days. Her temperature was 100° F and physical examination was essentially negative. She was advised to go to bed and take aspirin as needed for the aching.

After finding that this patient had been with E. H. on the trip to the aviary, G. D. was called and asked to come back to the office on June 23.

At that visit she stated that she had not been in bed but still felt badly and thought she had fever part of the time. Her temperature was 98°. She had no cough and no abnormal physical findings.



She was given a prescription for terramycin and blood was drawn for complement fixation for psittacosis and sent to Doctor Minton.

The report received on June 28 was positive for psittacosis in dilution of 1:4. G. D. at that time stated that she felt much better.

On July 27 more blood was drawn for confirmation and was reported by Doctor Minton as complete fixation at 1:32. Another sample was reported from the Public Health Laboratory as positive at 1:8.

CASE 3.—C. D., a 61-year-old white male rural route carrier, and the husband of G. D., also visited the aviary on May 27, 1951. He came to the office with his wife on June 7 complaining of generalized aching. His temperature at that time was 98°. At no time was he sick enough to stop work although he stated that he felt badly for some time afterwards.

Blood drawn for complement fixation for psittacosis on September 27 was reported by Doctor Minton as positive at 1:32.

#### *Summary*

Five adults spent several hours on May 27, 1951, visiting a parakeet aviary. The owners of the aviary were convalescing from an illness that had been diagnosed as virus pneumonia. The two younger members of the group did not become ill, but the three older members of the group were all ill on June 7.

One of the group, E. H., became quite ill, was hospitalized and developed a typical case of psittacosis which was verified by positive complement fixation tests in increasing titers.

The other two patients were ambulatory and their illness would not have been diagnosed as mild cases of psittacosis had not the previous

case been diagnosed and the common exposure to parakeets determined. They, too, had positive complement fixation tests to psittacosis antigen.

Although there are several reported cases treated with aureomycin and chloromycetin, no other cases have been found reported in American or English literature which have been treated with terramycin. The role that terramycin played in the recovery of these patients is difficult to determine as they had been ill for two weeks before the disease was diagnosed and terramycin started. However, the rapid defervescence of one patient and the symptomatic improvement in both cases in which it was used leads one to believe that terramycin played a definite part in their improvement.

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# THE PROBLEMS OF PARENTERAL NUTRITION IN THE SURGICAL PATIENT\*

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**B**ECAUSE a patient is able to survive critical illness, many of the minor complications and sequelae which are encountered in hospital illnesses are never recorded in the medical literature, nor in a resumé of the monthly vital statistics. About five years ago we became interested in these sequelae because they were an annoyance to us and distressing to the patient.

Our first studies<sup>1</sup> were directed toward the elimination of morphine as it was our impression that the excessive routine use of morphine, both in the pre- and postoperative period, might be contributing to some of these undesirable sequelae. This in turn led to a search for an analgesic in the postoperative period which would not produce the undesirable effects of morphine.

After several trials with other narcotics or analgesics, alcohol was added to the routine intravenous solutions of glucose, or glucose and amino acids. It became our impression that those patients who received alcohol, in addition to their intravenous glucose, or glucose and amino acids, were experiencing fewer sequelae, as well as relief from a considerable amount of their pain.

An analysis of 386 cases,<sup>1</sup> divided into those who received no morphine, but were supplemented with alcohol, and those who received morphine in the postoperative period, revealed a statistically significant difference in the incidence of cough, emesis, gas pains and catheterizations, in favor of those who received no morphine. (Figures 1, 2, 3, & 4).

In addition, the percentage of organic complications, such as pulmonary emboli, atelectasis or pneumonia, wound disruption or infection and thrombophlebitis, was definitely less in the no narcotic group:

	No Narcotics	Narcotics
Sharp chest pain -----	5.7%	11.8%
Emboli -----	.0	.4
Atelectasis or pneumonia--	.0	4.37
Thrombophlebitis -----	.0	3.9
Wound Infection -----	1.1	4.6
Evisceration -----	.0	.4
Ileus -----	.0	2.8
Diarrhea -----	1.1	7.2

Figure 1

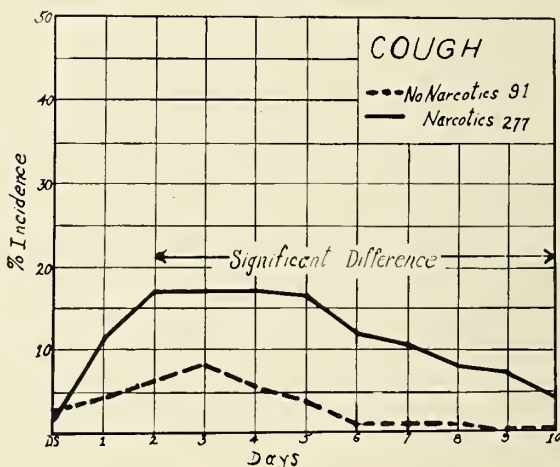
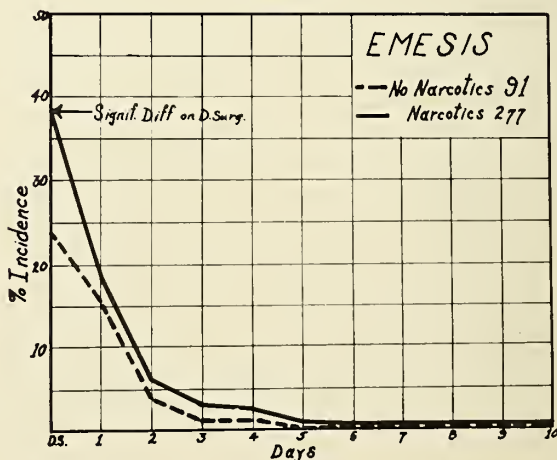


Figure 2



\*Presented at the Wells County Medical Society Fifth Annual Clinical Conference, Bluffton, Indiana, October 10, 1951.



Figure 3

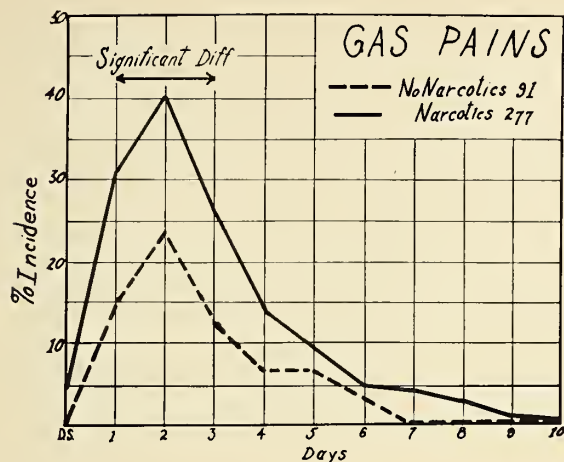
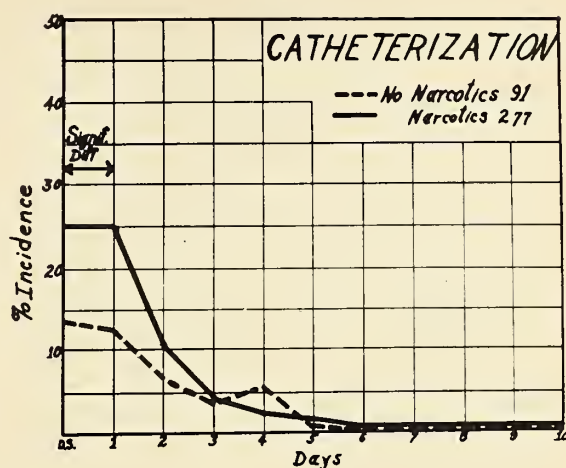


Figure 4



It also appeared that those patients who had received alcohol in their intravenous solution were being more easily ambulated and were regaining their energy more rapidly. Alcohol, undoubtedly, in the face of our subsequent studies, was providing additional calories.

#### *Investigative Studies Pertaining to Parenteral Nutrition*

Because of these early observations our subsequent efforts have been directed toward the value of adequate parenteral nutrition in the surgical patient who is unable to eat. Glucose, amino acids, alcohol, electrolytes, vitamins and water have been given intravenously, each separately, prior to the time that we began using them. Behan<sup>2</sup> in Pittsburgh had used a mixture of glucose, amino acids and alcohol in a marasmic child, and should, therefore, be given credit for having initiated the use of this mixture of nutritional elements.

#### *Blood Sugar Rise With Intravenous Glucose*

In a series of patients 5 percent glucose was administered intravenously over a period of four hours so that approximately 12.5 grams of glucose was given per hour. In this group of patients the blood sugar rose rapidly during the first hour and then leveled off at an average of approximately 180 milligrams percent.

When the same amount of glucose was given intravenously in conjunction with amino acids, or with amino acids and alcohol, there was no significant difference in the blood sugar level during the four hour period of administration.

These findings suggest that the extent of the

hyperglycemia is not influenced by the simultaneous administration of amino acids or alcohol.

#### *Blood Sugar Rise With Intravenous Invert Sugar*

Invert sugar has been found to be more readily metabolized from the blood stream than was found for glucose. Haldi, Beckman, Eusor and Wynn<sup>3</sup> found a greater percentage of glycogen in the liver in rats fed on glucose and fructose (invert sugar) than was observed when the rat was fed only one of these sugars.

Weinstein,<sup>4, 5</sup> observed that when invert sugar was given at the rate of 1.5 grams per kilogram per hour, the blood sugar level rose to an average of 215 milligrams percent.

In a series of patients in whom continuous intravenous nutrition was being provided over a period of several days with 12 percent invert sugar, 6 percent amino acids, and 5 percent alcohol, we found that the blood sugar level was maintained, on the average, at approximately 165 milligrams percent, with a range from 117 to 250 milligrams percent. This amount of invert sugar represents approximately 15 grams per hour, continuously.

#### *BLOOD SUGAR LEVEL DURING PARENTERAL NUTRITION WITH 12% INVERT SUGAR, 6% AMINO ACIDS AND 5% ALCOHOL*

Start—92.37	3rd Day—145.32	6th Day—165.33 mg. %
-------------	----------------	----------------------

It is seen, therefore, that invert sugar can be given intravenously at a more rapid rate, with less hyperglycemia than has been found possible with glucose. It has been observed<sup>6</sup> that fructose alone causes even less rise in the blood sugar

level than has been observed from invert sugar. It is possible that a greater proportion of fructose mixed with glucose might provide a better combination than is obtained from invert sugar which is a 50-50 proportion.

#### *The Loss of Sugar in the Urine During Intravenous Administration*

It has been variably stated that glucose can be administered at the rate of .8 gram per kilogram per hour,<sup>4, 5</sup> or .5 grams per kilogram per hour,<sup>7</sup> without significant glycosuria. If this amount of glucose were given continuously the quantity that could be administered in 24 hours would be enormous.

Five-tenths grams per kilogram per hour would represent, in the average sized man, approximately 850 grams of sugar in 24 hours.

Elmen<sup>8</sup> has observed that a greater percentage of utilization may occur if greater concentrations are administered, but this method of obtaining greater utilization seems physiologically uneconomic, as he found that the loss of sugar in the urine also increased.

It has been found, more often, that when 5 percent glucose is given intravenously at the usual clinical rate of 1 liter per hour, the loss of sugar in the urine may vary from 6 percent to 30 percent, whereas when invert sugar was given at the rate of 1.5 grams per kilogram per hour Weinstein observed that the loss of sugar in the urine was only 1.6 percent. With greater concentrations of invert sugar administered intravenously he observed somewhat greater losses in the urine.

These observations were conducted over a relatively short period of time and are therefore not entirely analogous to our observations.

Our studies with the continuous intravenous administration of invert sugar (12 percent), in conjunction with amino acids (6 percent), and alcohol (5 percent), over a period of six days revealed an average loss of 2.5 percent sugar in the urine.

Though the findings of different men have been variable, it appears that invert sugar can be administered in greater concentrations, with less loss in the urine and a lower degree of hyperglycemia, than is possible with glucose.

#### *The Caloric Value of Alcohol*

Alcohol has been used in our studies for its caloric value. It has a caloric value of 7 calories per gram or 5.6 calories per cc.

It has been indicated by Carpenter and Benedict<sup>9</sup> that the specific dynamic action for alcohol is approximately 7 percent.

Our determinations of the basal metabolic requirements before and after the administration of alcohol intravenously indicated an increase of 27 percent in the basal metabolic requirements at the end of three hours when 72 calories of alcohol had been administered per hour.

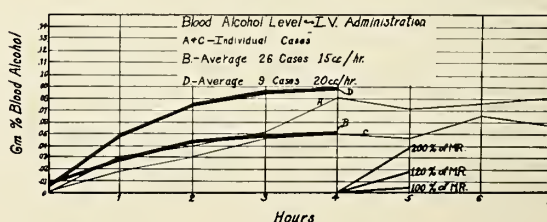
#### *The Rate of Metabolism of Alcohol*

It has been stated in the medical literature that alcohol is metabolized on the average at approximately 12 to 15 cc. per hour. The caloric value of this amount of alcohol (67C—84C) represents approximately the number of calories that are consumed per hour by the average individual. In other words, if an individual is metabolizing 56 calories per hour he should be able to utilize 10 cc. of alcohol per hour without appreciable evidence of alcohol in the blood.

In an effort to determine whether or not there was any relationship between the metabolic requirements of the individual and the amount of alcohol that could be metabolized, four patients were given their caloric requirement in alcohol for one hour. At the end of the hour the blood alcohol determinations were done. The blood alcohol of these patients average less than .01 grams percent. This insignificant rise in the blood alcohol level suggests that the amount of alcohol that can be metabolized by an individual depends upon the individual's metabolic requirement.

When three patients were given alcohol at the rate of 120 percent of their caloric requirement for one hour, their blood alcohol rose to .02 grams percent, and when two patients were given

Figure 5





alcohol at the rate of 200 percent of their caloric requirement in one hour, the blood alcohol levels rose to .04 grams percent. (See inset in Fig. 5)

*The Rate of Administration of Alcohol*

In order to determine the most desirable rate of administration for alcohol, it was administered to a group of patients at variable rates.

When alcohol was given at a rate of 20 cc. per hour continuously, it was observed that there was a sharp rise in the blood alcohol level to .06 grams percent in the first hour. Thereafter, there was a tendency for the blood alcohol level to rise less slowly over a period of four hours, during which the rate of administration was maintained constant. (Fig. 5)

When alcohol was administered at the rate of 15 cc. per hour, the rise in the blood alcohol level was less rapid and on the average it did not exceed .05 grams percent.

When alcohol is given at a constant rate for several hours the blood alcohol level does not rise as rapidly in each successive hour, but demonstrates a tendency to level off in each succeeding hour. This finding suggests that alcohol in itself increases the rate of metabolism.

In that the average hospital patient metabolizes approximately 100 calories per hour, these determinations and our clinical observations have indicated that the average patient can tolerate 15 cc. of alcohol per hour without producing undesirable toxic symptoms.

*The Value of Alcohol Calories*

The problem of providing adequate calories parenterally has been difficult principally because hypertonic solutions of glucose have been relied upon to provide the additional calories. The practice of using hypertonic solutions of glucose in order to provide more calories caused local

reactions in the vein or resulted in diuresis with a considerable loss of sugar in the urine, defeating thereby the purpose for which it was intended.

In an effort to demonstrate the value of alcohol calories in aiding a more favorable nitrogen balance, studies were done on several patients. The amino acid calories were kept constant. The glucose and alcohol calories were varied. In each instance it was observed that a more favorable nitrogen balance was obtained when alcohol calories were added. This is illustrated in Table I.

Studies were again done on three patients covering a total average period of ten days in which these patients received glucose and amino acids, and another period of ten days in which they received glucose, amino acids and alcohol. The glucose and amino acid intake remained essentially constant in both periods. The only nutritional factor that was altered was the addition of alcohol calories. During the period in which no alcohol calories were given, the average nitrogen balance was  $-.6$  grams per day. During the period in which alcohol calories were added the average nitrogen balance was plus five grams per day. Alcohol calories changed the average caloric balance from 72 percent to 103 percent.

These findings would seem to suggest that alcohol can provide immediately available additional calories, thereby sparing the glucose and amino acids which would otherwise be used for calories.

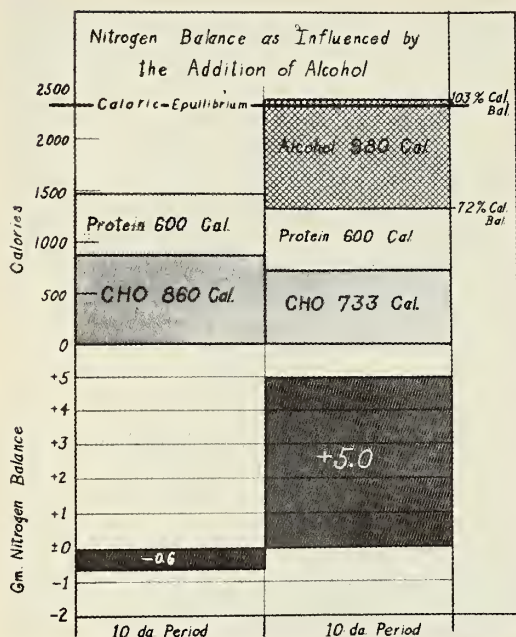
*Other Effects From Alcohol*

Though we are chiefly concerned in the caloric value of alcohol, there are other desirable effects which should promote benefit in the sick individual. It is considered that alcohol increases the capillarity, thereby improving the peripheral cir-

TABLE I  
THE VALUE OF ALCOHOL CALORIES

Period	Mr. H.		Mr. L. W.		Mr. C. J.	
	I	II	I	II	I	II
	3 days	2 days	2 days	3 days	4 days	4 days
I. V. Am. Ac. Cal. -----	600	600	600	600	600	600
I. V. Glucose Cal. -----	1000	1500	600	1000	600	600
I. V. Alcohol Cal. -----	672	0	1008	0	1260	0
Total -----	2272	2100	2208	1600	2460	1200
Grams Nitrogen Bal. -----	+4.1	+1.1	+6.2	-2.8	+4.9	-.2

Figure 6



culatation; it slows the respiration and increases its depth, causing thereby a greater pulmonary exchange. This should aid in decreasing the incidence of pulmonary complications; it serves as a mild analgesic and a sedative; it relaxes the gastro-intestinal musculature, whereby trigger zones or areas of spasm in the gastro-intestinal tract may be eliminated. This factor may contribute to the decreased incidence of gas pain which we have observed. Alcohol diminishes bladder and sphincter spasm and thereby decreases the need for catheterization; it is a mild diuretic, probably through its effect on the peripheral capillaries of the kidneys; it should, thereby, aid in kidney function. It gives the patient a feeling of ease and comfort when the blood alcohol level is slightly elevated.

In order to obtain the side effects from alcohol, the blood alcohol level must be elevated to .05 to .09 grams percent. This can be done by increasing the rate of administration, or by increasing the volume of alcohol in each liter.

#### *The Value of Amino Acids*

All body tissues contain nitrogen. Fat and bone contain relatively small amounts, but nitrogen is found in the nucleus of these tissue cells.

Amino acids, the digest product of protein, is the only source from which nitrogen can be

obtained for utilization in the body. Nitrogen is required for the building of new cells. In illness cells are destroyed or damaged and are, therefore, in need of repair. If nitrogen food is not consumed to provide the source of nitrogen, the nitrogen is taken from other tissues of the body to provide for the more urgent need of healing tissues. This is so whether the need is for surgically damaged or medically damaged tissues.

Numerous studies have been done to illustrate the value of amino acids. Considerable controversy has arisen as to whether or not amino acids can be utilized when given intravenously. When an analysis is made of the studies which have been done by these various investigators it is usually found that those who reported positive nitrogen balances had also administered more calories, whereas those who reported negative nitrogen balances had, on the whole, provided inadequate calories. Each came to his respective conclusion.

#### *The Caloric Requirements of the Patient*

In studying the nitrogen balance in a number of patients it was observed that variations seemed to occur even when all nutritional intake was kept constant. Realizing that there can be variations in the caloric requirement of the individual from time to time, it was decided to assay these variations. The principal factors in the changes of the metabolic requirement arise from fever and activity.

It was determined that bed activity on the average increased the basal metabolic requirement approximately 30 percent. It is known that fever increases the basal metabolic requirement by approximately 8 percent for each degree of fever. The caloric requirement for specific dynamic action may be variable. In our patients we have allowed 8 percent additional for this factor. When these factors were taken into consideration, the calculated total metabolic requirement closely approximated the metabolic requirement as measured on the Jones' metabolism apparatus. These figures are illustrated in Table II.

Since the calculated and the measured metabolic requirements have been found to approximate closely one another, we have determined that it is possible, for clinical purposes, to calculate the metabolic requirement of all patients, with the use of a slide rule designed for calcu-



TABLE II  
THE CALCULATED AND MEASURED  
METABOLIC REQUIREMENTS

Patient	E. J.	E. H.	W. C.
Calculated BMR -----	1449	1701	1853
Fever Requirement ----- (8% per degree)	81	272	444
Specific Dynamic Action-- (8% of BMR)	135	136	148
Bed Activity ----- 30% of BMR	506	510	556
Calculated Total -----	2171	2619	3001
Measured Metabolic Requirements -----	2422	2653	2925

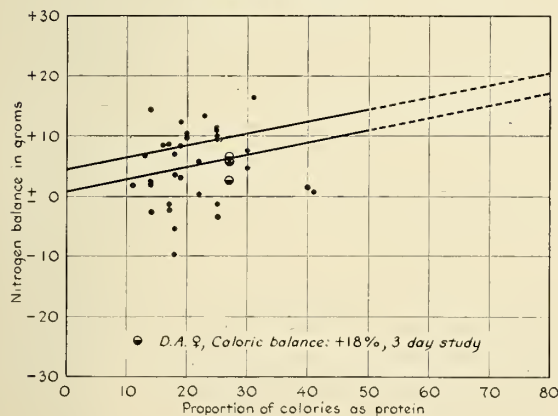
lating the metabolic requirements of the diabetic patient.

#### *The Significance of Calories and Protein In Relation to the Nitrogen Balance*

When all of our nitrogen balance figures were correlated on this basis and put to statistical proof it became possible to establish a definite correlation between the nitrogen balance, the caloric balance and the percentage of calories which were derived from protein.<sup>10</sup> These findings are illustrated in the following graph:

Figure 7

Range of Caloric Intake Above Metabolic Requirements  
+10% to +30%



In the graph which illustrates a caloric equilibrium (Fig. 8) the nitrogen balance is positive when 15 percent or more of the calories are derived from protein, whereas when the caloric intake is below the metabolic requirements, more

than 30 percent of the calories must be derived from protein in order to maintain a positive nitrogen balance. (Fig. 9.).

Figure 8

Range of Caloric Intake Above or Below Metabolic Requirements  
+10% to -10%

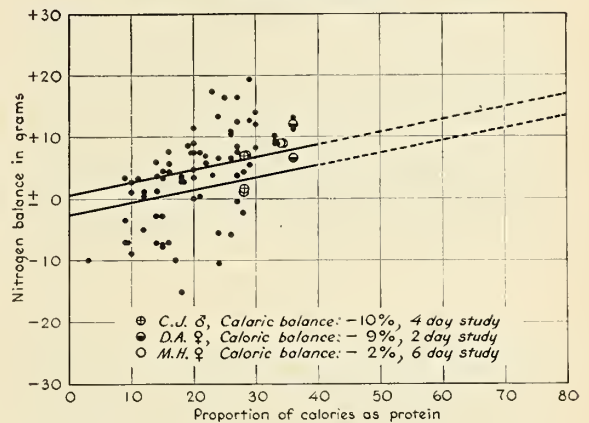
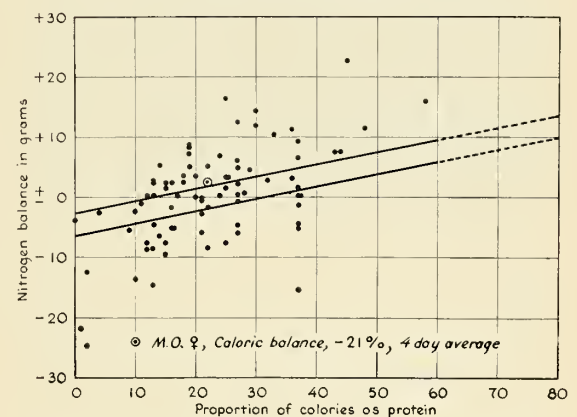


Figure 9

Range of Caloric Intake Below Metabolic Requirements  
-10% to -30%



From these studies we have learned that if a patient is to be maintained in positive nitrogen balance he must receive a very high proportion of his calories from amino acids or else he must receive a high caloric intake with an average amount of amino acids.

#### *The Electrolytes*

It is important that the normal electrolyte status of the surgical patient be maintained at all times.

An analysis of the electrolyte pattern of the blood in a small group of patients who received only parenteral nutrition for six days has indicated that when the patient receives 27 meq/l of potassium and 120 meq/l of sodium in the solution which we have been using, the electrolyte

Figure 10

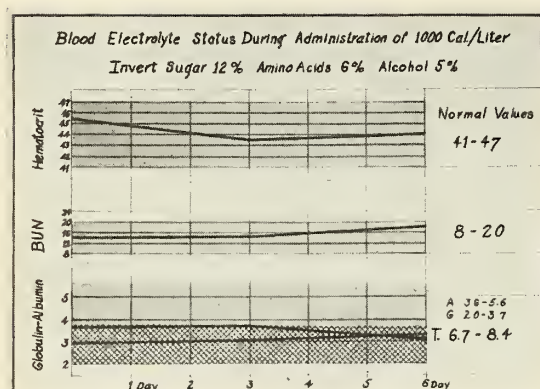
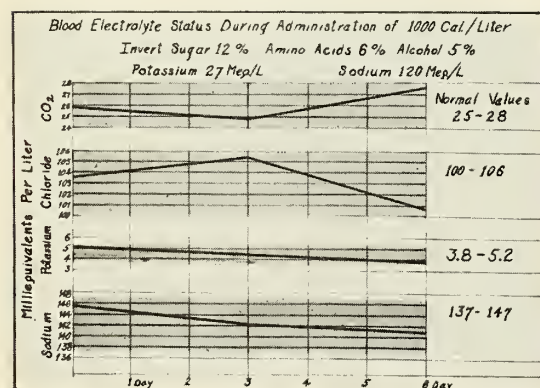


Figure 11



pattern of the blood is maintained within normal limits.

It has been observed, however, that there is an increase in the potassium excretion and a decrease in the sodium excretion in the postoperative period, with an associated negative potassium balance and a positive sodium balance.

These preliminary findings suggest the need

Figure 12

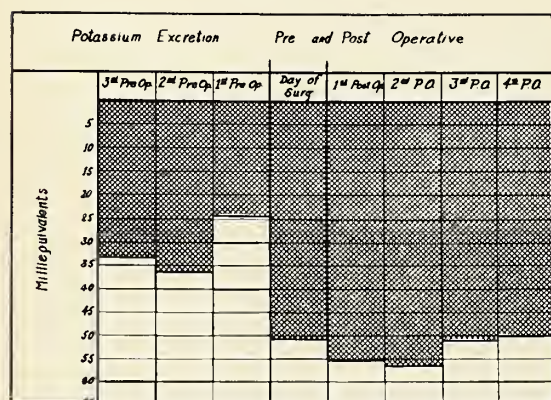
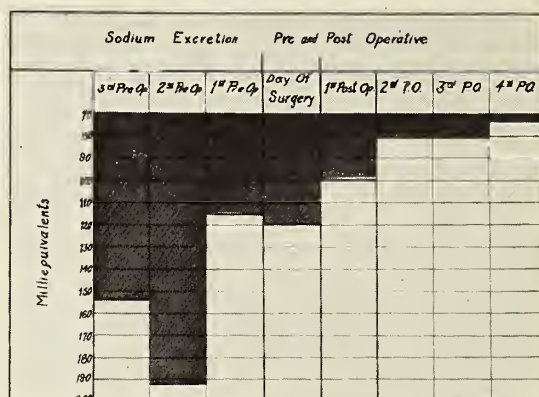


Figure 13



for a more accurate evaluation of the electrolyte needs in the postoperative period. From a clinical standpoint it has been our observation, however, that it is infinitely easier to maintain a normal electrolyte balance by providing adequate parenteral nutrition, than it is to correct an imbalance which has developed after a period of inadequate nutrition.

### Clinical Application

The average hospital patient requires approximately twenty-five hundred calories in order to be maintained in caloric equilibrium. The average hospital patient also requires approximately 2,500 cc. of fluid in order to be maintained in water equilibrium. If more fluid is given, there may be danger of overhydration, and if fewer calories are given, the patient is in negative caloric balance, as well as negative nitrogen balance.

This then led us to the need for devising a solution which would provide one thousand calories per liter.

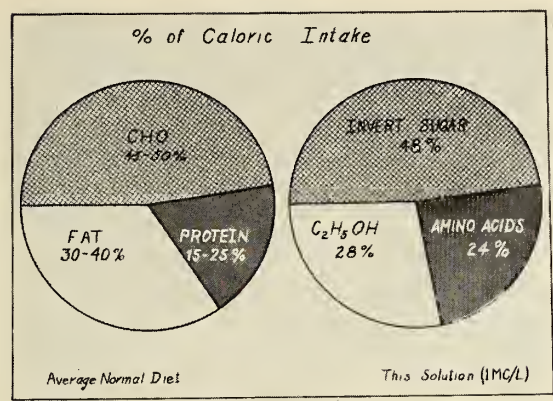
### A Parenteral Solution Containing One Thousand Calories Per Liter

The average individual consumes approximately 45 to 50 percent of his calories from carbohydrates, 15 to 25 percent of his calories from protein, and 30 to 40 percent of his calories from fat. The principal value of fat in parenteral nutrition is that of providing calories.<sup>11</sup>

With these thoughts in mind it has seemed desirable that we should devise a solution for parenteral use approximating these proportions of carbohydrates, amino acid and calories.



Figure 14



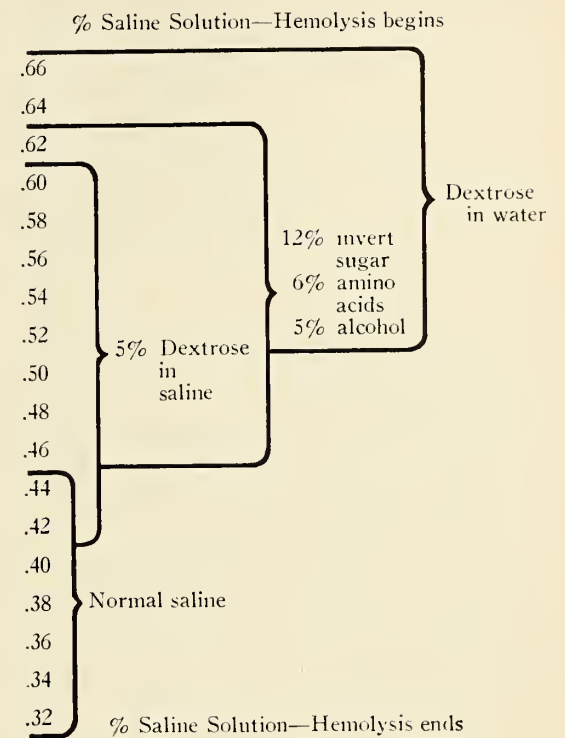
This we have been able to accomplish with the use of invert sugar, amino acid and ethyl alcohol, as indicated in the following table.

PARENTERAL SOLUTION CONTAINING ONE THOUSAND CALORIES PER LITER <sup>12</sup>				
Portion of calories				
	Grams	Caloric Value	This Solution	Ideal
Invert Sugar	120 gm.	480 C	48%	45-50%
Amino Acids	60 gm.	240 C	24%	15-25%
Alcohol	40 gm. (50 cc.)	280 C	28%	30-40%
H <sub>2</sub> O	1000 cc.			
Total		1000 C	100%	
Sodium 120 meq/l				
Potassium 27 meq/l				

This solution contains sodium and potassium in sufficient amounts to maintain the average daily requirements. Parenteral Pan vitamins and additional sodium or potassium can be added as becomes necessary.

This solution, which we have dubbed 1 MC/L (one thousand calories per liter) has a Ph of 5.55. Its hypertonic effect on the red cells was significantly no different than that which was observed from 5 percent glucose in saline. This was determined by exposing washed red blood cells to the solution for one-half hour. The cells and solution were then placed in standard solutions of sodium chloride as is done for determining red cell fragility. A comparison of the

fragility reactions is indicated in the following table:



Likewise, there was no effect on producing hemolysis of the red cells when 3 cc. of heparinized blood was added to one cc. of the parenteral solution, (saline, 5 percent glucose, 10 percent invert sugar, 1 MC/L). This was allowed to stand for one-half hour. The plasma was then separated from the cells by centrifuging. Hemoglobin determinations were done on the plasma and a qualitative test done with guaiac solution. The results indicated that there was no hemolysis in any of these solutions.

Though this solution is hypertonic, the clinical manifestation of its hypertonicity, as indicated by its local irritation when extravasated into the subcutaneous tissue, was no greater than has been observed from the subcutaneous infusion of 10 percent glucose. When it has been inadvertently extravasated into the subcutaneous tissue, local redness and soreness has developed. There has been, however, no slough and no abscess formation.

This solution has been given to more than 100 patients. No harmful systemic reactions have been observed.

This solution can be given through an intravenous needle with no more reaction than is observed from the administration of 10 percent

glucose. We prefer, however, to use a long polyethylene tube and administer the solution slowly, around the clock, requiring approximately eight hours for each liter.

### *The Beneficial Results of Adequate Parenteral Nutrition*

In order to compare the benefits derived from adequate nutrition in the pre- and postoperative period, a group of consecutively operated gastric or colon resections were chosen.<sup>13</sup> In each instance a resection and primary anastomosis was done.

The cases were divided into two groups: those who received adequate nutrition and those who received inadequate nutrition. These figures are indicated in the following table:

INCIDENCE OF COMPLICATIONS IN  
RELATION TO CALORIC INTAKE

	Adequate Nutrition	Inadequate Nutrition
Total number of patients.....	46	44
Caloric Balance .....	92%	21%
Incidence of complications.....	17%	36%

NATURE OF COMPLICATIONS IN PATIENTS  
WITH GASTRIC OR COLON RESECTIONS

	Adequate Nutrition	Inadequate Nutrition
Pulmonary .....	1	9
Renal .....	1	0
Wound infection or dehiscence.....	2	4
Peritonitis, obstruction ileus.....	2	2
Thrombophlebitis .....	1	1

Here it is noted that though the nature of complications in both groups were essentially the same, the incidence of complication in the adequately nourished group was approximately one-half that of the inadequately nourished group.

### *Conclusions*

Invert sugar can be used in greater concentrations without producing as much hyperglycemia or as much glycosuria as is produced from glucose.

Alcohol can provide additional calories which, when used in conjunction with glucose and amino acids can contribute to a more favorable nitrogen balance.

A solution of invert sugar 12 percent, amino acids 6 percent, alcohol 5 percent, can provide one thousand calories per liter. This solution

can be given intravenously and continuously without producing undesirable systemic reaction. When electrolytes and vitamins are added to this solution a physiologically balanced proportion of nutritional elements can be provided parenterally to the patient who is unable to eat. With this solution it is possible to maintain simultaneous equilibrium in calories, nitrogen, water and electrolytes.

An analysis of two identical groups of surgical patients has revealed a lower incidence of postoperative complications in those who received adequate parenteral nutrition as compared to those who received inadequate nutrition.

In that adequate nutrition is a fundamental necessity for life and health, and in that no benefit, but considerable harm, can result from even a short period of starvation, it is our thesis that every patient who cannot eat adequately should be supplemented with parenteral nutrition to the full nutritional requirements until he is able to eat.

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# THE JOURNAL

## OF THE

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## INDIANA HEART FOUNDATION

**F**EBRUARY is traditionally the "Heart Month." It is the time of year when the Heart Foundation conducts its annual drive for funds, and centers its activities around the week in which Valentine's Day falls. In Indiana it has also become customary to conduct an annual symposium on cardiac disease some time during the month.

The program this year will be presented on Tuesday, February 5, at Indiana University School of Medicine. The evening portion of the presentation will constitute the monthly postgraduate telephone seminar. The detailed program, which presents essayists of national reputation in the field of cardiology, is reproduced on page 145.

February is also the time for review of the activities of the Heart Foundation. The year 1952 will mark the inauguration of the Indiana edition of the "Heart Bulletin." This is a publication which will be engineered by the Medical Arts Foundation and will be mailed to all the general practitioners of the state. Its contents will be

designed to assist in the diagnosis and treatment of cardiovascular diseases.

During the past year the Indiana Foundation has established a program of lay education which will be continued. This program has been planned with the assistance of other health organizations and with the help of leading educational groups. It is integrated with the school health program, and is primarily interested in instructing teachers, parents and students in regard to conditions of a cardiac nature for which the advice of a physician should be sought.

Heart disease is responsible for 10.2 percent of all deaths between the ages of six and nineteen years. This is the leading cause of death for this age group, with the exception of accidents. Surgical treatment of congenital anomalies, antibiotic treatment of subacute endocarditis, and improved therapy of rheumatic heart disease, has placed many conditions in the remediable and curable classifications, and makes early detection more important.

## RETIREMENT PLAN FOR PROFESSIONAL PERSONS

LEGISLATION has been introduced in the House of Representatives by Congressmen Keogh and Reed of New York under which lawyers, doctors, and other professional self-employed persons would be able to secure a postponement of Federal income tax on a portion of their earned income set aside for their own retirement.<sup>1</sup> Because they are self-employed they cannot qualify for the preferential tax treatment now accorded company-financed pension plans meeting the requirements of Section 165 of the Internal Revenue Code, according to the New York State Bar *Bulletin*.<sup>2</sup>

The foregoing legislation was initiated by the Committee on Personal Income Taxation of the New York State Bar in June, 1950, and the efforts of the Committee came to partial fruition in 1951 when a bill prepared by it in cooperation with special committees of the American Bar Association and the Association of the Bar of the City of New York was introduced as stated above and was later proposed in principle by Senator Ives of New York as an amendment to the 1951 Revenue Bill.

This legislation, while not favorably acted upon by the Congress at the 1951 session, has widespread and bipartisan support. It is understood that the Senate Finance Committee has referred the proposal to its technical staff for study and later report. The plan, if enacted, would permit lawyers, along with doctors, accountants, farmers, proprietors of small businesses, and others, to obtain a tax deduction for limited amounts paid into a so-called "restricted retirement fund" sponsored by a bona fide business or professional organization of which they are members. The annual deduction would be limited to the lesser of \$7,500 or 10 per cent of "earned net income."

The fund would be administered by a bank as trustee which would have the power to invest and reinvest the contributions in "legal" investments. No retirement benefits would be payable prior to age sixty except in case of permanent and total disability. At age sixty or later, each participant would have the option whether to take his benefits in a lump sum in a series of annual payments, or in the form of an annuity policy with or without survivorship option and guaranteed minimum payments.

If the lump sum method of distribution were elected, the amount would be taxed when received at capital gain rates, that is, at not to exceed 25 percent. Under the other optional methods of distribution, the recipient would be taxed at ordinary income rates as and when he received distributions. It is contemplated that at age sixty or later his deferred income will fall into lower surtax brackets

since his earnings will either have ceased or have passed their peak.

The plan already has the active support of the American Bar Association and of many other professional organizations such as the American Medical Association, the American Dental Association, the American Institute of Accountants, and the Authors' League of America, Inc. The House of Delegates of the Medical Society of the State of New York has approved this legislation, but that fact in itself is not enough; in order for the plan ultimately to become law those who are affected by it and are in favor of it must make known their interest to their Congressmen and Senators.

It is probable that many physicians would favor such a retirement plan. But to put it into effect legislation must be enacted by the Congress of the United States. The Representatives and Senators of this State have no way of knowing who does or who does not favor it unless in some way the physicians of the State tell them either verbally or in writing. Little can be accomplished by mere wishful thinking.

It is absolutely necessary for each doctor of medicine to communicate personally with his Representatives and Senators if he wishes to request them to support the Keogh-Reed Bill and its Senate counterpart, the Ives amendment to the Internal Revenue Bill of 1951.

<sup>1</sup> H. R. 4371 and H. R. 4373.

<sup>2</sup> October, 1951, p. 333.

—New York State Journal of Medicine

## DIABETES JOURNAL

INAUGURATION of *Diabetes*, The Journal of the American Diabetes Association, was announced by the association recently. The new Journal, which will appear bimonthly beginning with the January-February 1952 issue, will be devoted to clinical and research reports on diabetes and related aspects of medicine. It will be the association's official scientific and organizational publication, replacing its annual *Proceedings* and its quarterly *Diabetes Abstracts*, both of which have been published for the past ten years.

*Diabetes* will be edited by Frank N. Allan, M.D., of the Lahey Clinic, Boston, Massachusetts, first vice-president of the American Diabetes Association. Doctor Allan will be advised and assisted by a distinguished Editorial Board under the chairmanship of Charles H. Best, M. D., University of Toronto. Franklin B. Peck, M.D., Indianapolis, will be a member of the Board. William R. Kirtley, M.D., Indianapolis, will be the abstracts editor.



## MEDICAL COSTS AND INFLATION

**E**ACH year the U. S. Department of Labor publishes its report on the cost of living. A figure of 100 is used to represent the cost during the base period, 1935-39. Data have just been released for 1950. For that year the cost of living index was 171.2, an increase in ten years of 71.2 percent.

Each year, also, the A.M.A. Bureau of Medical Economic Research analyzes the labor statistics for medical care and its component parts. In 1950 the cost of all medical care including drugs had increased only 47.9 percent. This is a creditable figure when considered in relation to the price rises for many other things.

The components of medical care vary considerably in price rise, some small, some high. Physicians' fees in 1950 had increased 40 percent, drugs only 24.8 percent. Hospital expenditures showed the greatest increase of all, 135.3 percent. Hospital rates are understandable when one considers to what extent the hospital is exposed to inflation.

Despite these rises the A.M.A. bureau finds that Americans are getting more and better medical care today than they were years ago for the same proportion of their budget. Average factory workers' wages in 1950 would purchase almost twice as much medical care as they would in 1940. Wages have increased much faster than has the cost of medical care.

As a part of the cost analysis the bureau found that the amount of services rendered by the average physician has increased in ten years by from one-third to one-half. This change is attributed to the highly effective new drugs, to improved transportation, and to other technical improvements.

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## HOSPITAL CONSTRUCTION REPORT

**T**HE A.M.A. Washington Office has forwarded the following report on all Hill-Burton hospital construction in Indiana. There are now completed and in operation 20 projects, built at a total cost of \$10,012,002, and with a total bed capacity of 653. Seventeen projects are under construction, with a bed capacity of 1016, and cost of \$20,653,219. In addition to the above there are 4 projects approved, but not yet under construction. This group will supply 329 additional beds at a total cost of \$4,038,260.

## *Letter to the Editor*

Frank B. Ramsey, M.D., Editor,  
Journal of the Indiana State Medical Association,  
201 Hume Mansur Building,  
Indianapolis 4, Indiana.

Dear Doctor Ramsey:

We are writing to extend a cordial invitation to your readers to attend a three-day Sectional Meeting of the American College of Surgeons to be held at The Radisson Hotel in Minneapolis, Minnesota, on March 24, 25 and 26.

The program will include two days of scientific sessions at The Radisson Hotel and a day of teaching clinics and demonstrations in Minneapolis hospitals. Distinguished speakers will present papers, panels and symposia on current surgical problems, and extensive programs for specialists in Ophthalmology and Otolaryngology have been prepared for March 25th. New surgical motion pictures will be shown, including several which were prepared especially for the Cine Clinics at the 1951 Clinical Congress, and also a stereoscopic colored film on Radical Resection for Carcinoma of the Stomach, which is attracting a great deal of attention wherever it is shown.

Doctor Harvey Nelson and his Committee on Arrangements have made extensive preparations to assure a good meeting and a warm welcome to Minneapolis for all visiting surgeons. Hotel accommodations may be obtained by writing to Mr. Neil Wilsey, Front Office Manager in Charge of Reservations, The Radisson Hotel, Minneapolis 2, Minnesota.

Sincerely yours,

H. P. Saunders, M.D., F.A.C.S.  
Associate Director.

The Interim meeting of the House  
of Delegates of the Indiana State  
Medical Association will be held  
April 27 at the Claypool Hotel. Fur-  
ther details will be announced later.



## President's Page



ON DECEMBER 29 Mrs. Max Woolen McCaskey was called suddenly from her earthly abode by a heart attack, the fifth in a series which extended over a period of two years.

Max, or Mrs. Mac, as she was familiarly known to her many friends and acquaintances, was the wife of Dr. Carl H. McCaskey, a past president of the Indianapolis Medical Society, the Indiana State Medical Association and the Indiana and American Academies of Ophthalmology and Otolaryngology.

Over the period of years that Mac served in the various offices Max was his constant companion, and perhaps no physician's wife in the state or nation was more widely known. No medical gathering seemed quite complete without the jovial countenances of Max and Mac.

In her earlier years Max had developed a very fine technique on the violin and many an hour she spent at her music, accompanied by her mother at the piano.

Max was a great lover of the out-of-doors life and thoroughly enjoyed the flowers and scenery on the many tours she and Mac had taken, and which she recorded by hundreds of feet of motion pictures.

Max took to golf some years ago and the natural rhythm in her swing placed her among the interesting contenders for top honors. She was twice president of the Indiana State Women's Golf Association and remained active in the association until ill health forced her retirement. She then became a most ardent hockey fan and seldom missed a game at the home rink.

With all the desire to be active there was a sense of utmost fairness, one of extreme refinement and appreciation of artistry.

In addition to the husband, the survivors are a daughter Lois and two grandchildren.

It is with sincerest regrets that we say, "Goodbye Max, Goodbye Mrs. Mac, your fine character will linger long in the memories of your friends. You have truly made this a finer world in which to live."

Our heartfelt sympathy is extended to Mac, Lois and the two grandchildren.

Sincerely,





# Medical Panorama *by the* ASSOCIATE EDITOR

## THE G.P. HIS OWN DERMATOLOGIST

In the *Illinois Medical Journal* for October, 1951, there is an article by D. Cohen, M.D., and M. Goldin, M.S., on "Superficial Fungus Infections" which indicate that the general practitioner has at his disposal an accurate means of diagnosing such infections without resort to methods requiring cultures and other specialized techniques.

The summary follows:

1. In a series of 1000 cases of possible tinea pedis, 48.8% were positive for fungi on direct mount. Of these 488 cases, only 32.4% were positive by culture.

2. Reliance on a properly prepared direct KOH mount of a scraping from the feet should, in a high percentage of cases, be sufficient to establish the mycotic etiology of an infection. This is of the most practical importance, since it dictates subsequent therapy. The addition of the culture method, although ideal, is of limited value except under special circumstances.

The method used is described, also:

**Materials and Methods.**—Skin scrapings from the periphery of lesions and/or the roofs of intact vesicles were taken. These were placed on a slide, a drop of 10% KOH and a cover slip were added, the preparation warmed gently to facilitate clearing and the slides studied microscopically for the presence of mycelial elements.

The only catch here is to know a mycelium when you see one, but a little practice should work wonders. In addition, any given puzzling slide can always be sent to a real bacteriologist for his opinion.

## READ BEFORE THROWING AWAY

For those who may consider "Health Bank Notes" (published by Blue Cross-Blue Shield) as "throw away" stuff, the following bit gleaned from the October, 1951, issue may be of interest. Surely, doctors should keep up to date on all such matters:

Blue Cross DOES NOT provide:

- a. . . . for payment to hospital for service rendered when for rest cures, physical examinations or for observation or diagnostic purposes only.
- b. . . . for blood and blood plasma (however, all hospital services in connection with typ-

ing donors and processing and administering the blood is provided).

- c. . . . for hospital care as a result of injury on the job covered by Workmen's Compensation or similar laws.
- d. . . . extraction of teeth.
- e. . . . ambulance service.
- f. . . . services of private duty nurses.
- g. . . . conditions for which care is received in a veterans', marine or other Federal hospital, or to the extent received from a governmental agency for injuries resulting from acts of war.

Blue Cross DOES provide:

- a. . . . for pre-existing conditions after the Comprehensive certificate has been in effect 9 months and the Standard certificate 10 months.
- b. . . . for maternity care, after the family Comprehensive certificate has been in effect 9 months or the family Standard Certificate, 10 months.
- c. . . . for anesthesia in full (for the Comprehensive member) when administered by a practicing physician who is a salaried employee of the hospital; otherwise, up to \$10 is paid for minor surgery and up to \$20 for major surgery. (For the Standard member, the allowance is \$10 in either case.)
- d. . . . for out-patient service for emergency accident cases only.
- e. . . . hospital care for tuberculosis and mental cases up to 30 days per year. (Comprehensive members can receive an additional 30 days' service for the same condition if six months elapse before the readmission.)

In addition, Blue Cross does not provide for x-ray and radium therapy in the hospital since Blue Shield makes provisions for indemnity allowances for these services.

It is hoped that members will read their certificates carefully for a complete statement as to the services provided.

## EXCERPTS FROM SPEECHES OF SENATORS BYRD AND TAFT

*On these two pages are excerpts from the speeches made by Senator Robert A. Taft of Ohio and Senator Harry F. Byrd of Virginia before the House of Delegates of the AMA at the Fifth Annual Clinical Session in Los Angeles, December 5.*

### SENATOR HARRY F. BYRD:

Many are warning us as to what may come unless we change our governmental course, which in the late years has been proceeding steadily towards state socialism. Some call the present trend collectivism, some call it statism, and some call it the welfare state, but let us not be technical as to the name of this new "ism." I would call it "ruinism" because these new policies of government, unless quickly checked, will destroy the American system.

For those who think "a little socialism" is a good thing, there is the British example. From what we see in England, we would be the most stupid nation on earth if we allowed ourselves to become further embraced by the socialism which has been creeping upon us. Socialism and free enterprise cannot live under the same roof.

As I see it, the welfare state, about which we have been hearing so much in recent years, is that state of twilight in which the glow of democratic freedoms is fading beyond the horizon, leaving us to be swallowed in the blackness of Socialism, or worse.

Make no mistake: It is Socialism which lies at the end of this rainbow, and, in this rainbow, the predominating color is the red of federal deficit spending under which a whole new generation of Americans has grown and developed.

Adoption of the Truman Fair Deal program, as he has outlined it . . . and recently reaffirmed it . . . would irrevocably put us on a one-way street to State Socialism.

Socialism can be effectively promoted by constantly increasing those who are on the public payroll. A population of government dependents is a socialized population.

Among the cardinal characteristics of socialism are government subsidies with controls, and government doles with regimentation. I am against that.



Senators Robert A. Taft and Harry F. Byrd

The American Medical Association needs no definition of the free enterprise system from me. It is the system which, in the relatively short span of one hundred sixty years, has brought us from the impotency of thirteen un-united colonies to our present position of world leadership. I do not concede that it should be scrapped for socialism in welfare state clothing which never brought greatness, happiness or security to any nation.

I do not concede that either democracy or free enterprise, or any other American freedom has run the course of its usefulness in the world. They have been worth fighting for in the past against both economic and military challenge, and I do not concede that they were any dearer to those who have fought and won before than they are to us today. The battle lines are drawn. I am ready to fight. I hope you are. The forces of freedom in America need recruits.

The American Medical Society has waged a clean—aboveboard—effective campaign against socialized medicine. You are fighting to preserve the great principles of our Republic. You realize, as all of us should, that socializing an important segment of our daily life means that sooner or later further socialism will encompass other activities, resulting in a complete socialistic regime.

In conclusion, let me say, we should always remember that human freedom is not a gift to man: it is an achievement by man, and, as it was gained by vigilance and struggle, so it may be lost by indifference and supineness.



## SENATOR ROBERT A. TAFT:

The fundamental problem before the American people today is how best to maintain the great progress they have made under liberty, and pursue their destiny to higher spiritual and material goals. That liberty is threatened by the forces of communism from abroad. It is threatened by the growing socialism and government control at home.

Liberty includes your right to choose your own occupation and run your own professional activities or business or farm as you see fit to run it, except for such control as may be necessary to assure a similar freedom to others.

This liberty is threatened today by what is roughly called socialism. By that I mean the growing power of government in the affairs of all of you individuals, and its increased activity in many fields where it has never heretofore been involved.

It has taken over functions which were almost exclusively local, and it threatens to take over all welfare services through a scheme known as social insurance which is not insurance, but simply more taxation to support free federal welfare services.

The American Medical Association has taken the lead in opposing this trend, and the doctors are justified in this because the key move of the socialists today is the effort to set up a federal system of socialized medicine.

But medicine is only the opening wedge. In Great Britain the government furnishes free service for the birth of babies, for the support of children, for burial at death, and for every misfortune of life. That is the goal of our Federal Security Administration as set forth in several of its annual reports.

What is the purpose of this vast expansion of government activity? Supposedly it is for the welfare of the man of low and middle income, but they have it all in England and the British workman gets wages equal to about 40 percent of what the American workman gets, and has less than half the standard of living.

Socialism draws a beautiful blueprint, but it utterly destroys the incentive of the individual manufacturer or the individual workman. In its effort for equality, it reduces everyone to the dead level of mediocrity.

A lot of those taxes are passed on into the cost of goods which you buy. Even the man of lowest income today already pays 20 percent of his income

in taxes, either directly or in the increased price of every article that he buys.

You are thus deprived of the liberty of spending the money that you have earned. The government spends it for you. If the present increase goes on, the time will come when the government takes 75 percent of your income.

But those who dwell on the importance of liberty must recognize the proper functions of government, and their case is weakened unless they recognize that there are necessary limitations even on liberty.

First. Government action may be necessary to maintain a limited liberty for all in our complicated modern life.

Second. We have found that some government regulation is necessary if we are going to retain liberty itself in business.

Third. Government certainly has the obligation in this country to relieve hardship and distress where private charity cannot do it.

I quite agree that when you get in this field on an extensive basis you have to be careful not to go on to socialistic service for all. In fact, in free schools and in the old age and survivors insurance system we have taken two steps into socialism; but I do not think that term can be applied to the charitable effort to remove extreme hardship and distress.

If we don't want charity to develop into socialism, however, there are certain definite rules to be followed. First, there must be state and local control, and the service must under no circumstance be federalized.

With the tremendous military spending we now face, I doubt if we should undertake any additional program no matter how meritorious. My own feeling is that we endanger the whole economy of this country if we permit the total tax burden to run over 25 percent of the income of all the people. Where it has reached 40 percent, there is no longer any incentive for private development, and little doubt that socialism will continue to spiral upwards.

If we can preserve liberty in all its essentials, there is no limit to the future of the American people. There are no frontiers to human improvement. The progress that America has made can be an example for the entire world to follow, while we go on still further to open new opportunities for all mankind.

# MEDICAL DIRECTION FOR THE NURSE IN INDUSTRY

## SECTION 1

### Introduction

The past few years have seen a great industrial expansion in Indiana, and with this, a greater increase of in-plant medical services to the worker. This trend has added greatly to the responsibility of the industrial nurse as well as to the doctor. In the large plant, with its well-equipped dispensary and its wide field of medical services, there may be a doctor constantly in attendance who can administer to each case as it arises, and thus seldom will the nurse in such a plant find herself forced to act on her own initiative.

Such a program, however, is available only to a minority of the industrial workers in Indiana at the present time. Most industrial workers in our state are housed in smaller plants. Some have no in-plant medical facilities; some have only part-time medical or nursing attendance; some have full-time nursing and part-time or on-emergency call medical attendance. It is to the nurses in these latter situations that these directives are submitted, and it is these nurses who need this aid.

It is recognized that in each plant the nurse's program may vary greatly. She may be associated with other nurses in a busy dispensary, she may be assisted by trained lay employees, she may work entirely unassisted, or she may make only a short daily visit to the plant, depending upon the individuality of that plant. *She should always have a doctor to call for counsel or to meet an emergency. To deny her all initiative in the minor injury or the evident trivial complaint is impractical.* The nurse who occupies such a position, properly trained, instructed and counseled, is not practicing medicine. She is practicing nursing—industrial nursing.

When an employee comes to the dispensary he is seen first by the industrial nurse. It is her duty to make a preliminary evaluation of his case by the same methods used by a doctor, that is, first obtaining his personal and occupational history, his complaint, then inspecting and evaluating objective evidence presented. Only after such a survey can she intelligently proceed with the proper management of the problem. It is assumed that she is a registered graduate nurse who, in addition to her basic nurse's training, has had special training and experience in the field of industrial nursing which would justify her accepting this responsibility. The beginner or the inexperienced nurse should not work without competent supervision. As her training and experience progress her responsibility will be correspondingly increased.

The "presenting complaint" of individuals entering the industrial medical dispensary will vary greatly as to onset, severity, duration and, too frequently, will be colored by the individual's interpretation of cause and effect. The nurse needs

to know, understand and like people, and be able to comprehend details of illness or injury poorly expressed; to uncover facts covered by opinion and conclusion. She must have knowledge of her own plant's processes and hazards; she must gain and maintain confidence and cooperation of both management and the worker, as well as complete confidence of her medical director.

She must be able to differentiate the trivial from the serious ailment and quickly recognize the emotionally induced or influenced complaint. In the following list are some of the more commonly met complaints or situations, in which the industrial nurse will be called upon to act. When they are reviewed, altered as indicated, and signed by the plant physician, or the supervising physician designated by the company, they will then constitute the "Standing Orders" for the industrial nurse.

## SECTION 2

### Complaints

#### ANOREXIA

May come from a number of causes, usually systemic and of natural origin. It will seldom need emergency care.

Treatment: Eliminate the possibility of inhalation or ingestion or other absorption of toxic substances. Further treatment should be at the direction of the physician after his diagnostic study.

#### DIAPHORESIS

Local—Probably a purely individual characteristic. It generally is only of nuisance importance.

Treatment: Use caution in advising the use of anti-perspirants.

General—May indicate some serious physiological disturbance if it is severe or will, if continued, lead to same.

#### Treatment:

1. Observe at once temperature, pulse, respiration and blood pressure.
2. Put patient at rest.
3. Sponge wet areas dry.
4. If not contraindicated, replace salt and fluid loss by mouth.
5. If problem is serious, refer patient to plant physician for further study.

#### DIARRHEA

Severity is variable. It is generally attributable to food intoxication, dietary indiscretion or inflammation of the gastrointestinal tract.

#### Treatment:

1. Observe carefully temperature, pulse, respiration and blood pressure and record.



2. Control cramping or tenesmus by drug selected by plant physician.
3. If persistent for more than two or three stools or for more than three or four hours, insist that patient consult his physician through consultation with the plant physician.

#### DIPLOPIA

Diplopia will seldom be a complaint but presence may be of great significance. If this finding follows a blow to the head or is of sudden onset, it is suggestive of intracranial disturbance and should receive emergency attention.

##### Treatment:

1. Put patient at bed rest.
2. Observe temperature, pulse, respiration and blood pressure for record.
3. Apply ice cap to head if temperature is elevated or there is evidence of contusion.
4. Medication of a small dose of aspirin or a mild sedative may be given.
5. Immediately inform plant physician.

If diplopia has been of gradual onset and not associated with trauma, it probably represents some progressive intracranial lesion or an imbalance of the ocular muscles and patient should be referred to doctor of his choice, by the plant physician.

#### DYSMENORRHEA OR METRORRHAGIA

With the great increase in women workers, many of them substandard or under emotional stress, the industrial nurse is called upon many times to relieve menstrual cramps. She must evaluate the severity, the danger symptoms of extensive hemorrhage, serious pelvic disease, pregnancy, threatened miscarriage or physiological dysfunction.

##### Treatment:

1. Put patient at bed rest.
2. Apply hot water bottle to the lower abdomen.
3. Use antispasmodics as previously directed by the plant physician.
4. If repeated episodes occur, refer patient to her physician for diagnosis and therapy.
5. For uterine hemorrhage, elevate foot of bed and call physician immediately.

#### DYSYPNEA AND CHEST PAIN

The common complaint of "shortness of breath" or "painful breathing" is frequently passed over too lightly. If onset is sudden and severe it is suggestive of cardiac or pulmonary disturbance.

##### Treatment:

1. Call plant physician immediately.
2. Put patient at rest in a tolerated position.
3. Administer oxygen if he seems to be in respiratory distress, or if cyanotic.

#### DYSURIA

Dysuria and frequency of urination are usually indicative of inflammation along the lower genitourinary tract. It is not necessarily infectious.

Treatment: A mild sedative or antispasmodic may give some temporary relief but an early diag-

nosis by a physician should be made. Disposition of the case must be made by the plant physician.

#### NAUSEA

Nausea is frequently associated with other symptoms of greater significance. If it is the single presenting symptom it probably indicates a simple gastroenteritis or food intolerance. It may be a symptom of an occupational disease.

##### Treatment:

1. Restrict diet to tolerated liquids.
2. An anti-acid of soda or some of the aluminum hydroxide preparations may be administered.
3. A mild sedative or an antispasmodic may be given if patient seems apprehensive or spastic and is without pain.
4. If occupational disease is suspected, the plant physician should be notified.

#### Pain

Pain is probably the most frequent complaint causing the employee to come to the industrial nurse. Careful consideration must be given of its character, location, duration and severity.

#### ABDOMEN

Abdominal pain may arise from any one of many causes. Therefore, before any procedure is decided upon, it is necessary to obtain at least a rudimentary history of the onset and development. Potential occupational exposures must be considered in the history.

##### Treatment:

1. Note and record the general condition of the patient, that is, his appearance, apparent pain, temperature, pulse, respiration, and blood pressure.
2. If the condition is recognized as critical, the physician must be called at once before any but emergency treatment is given.
3. If the symptoms are mild, conservative palliative therapy, as advised by the plant physician, is indicated.
4. Avoid use of any laxative.

#### BACK AND EXTREMITIES

Such complaints may arise from various real or remote causes. Obtain history of onset, type, duration of pain and record.

##### Treatment:

1. The nurse should be directed toward obtaining symptomatic relief, usually by rest, application of heat, or liniment to the affected part.
2. Internal medication of two or three aspirin, ASA compound or some similar preparation may be given as directed by the medical supervisor.
3. If symptoms do not abate, refer to plant physician for diagnosis, treatment, and disposition.

#### TOOTHACHE

There is probably no one phase of personal hygiene that is more neglected than dental care and oral hygiene. This leads to carious teeth

which may go entirely unattended until they begin to cause pain.

**Treatment:**

1. Pack cavity with small pledget of cotton saturated with oil of clove.
2. If the tooth is painful, apparently from an abscess at the root and no cavity is present, nothing more than mouth washes and analgesics are indicated from the nurse.
3. Refer to dentist for further dental care.

### EARACHE

Earache will frequently be seen as a complication of an upper respiratory infection.

**Treatment:**

1. For temporary relief, if it appears the patient has an engorgement of the nasal mucous membrane, use some bland nasal solution with vasoconstrictor action selected by the plant physician.
2. If it appears that the pain comes from the external ear canal, use a cotton pack saturated with solution of analgesic and hygroscopic action. Never irrigate or medicate an ear in which there is history of a perforated eardrum unless ordered to do so by a physician.
3. Refer to private physician for further care unless it is thought to be occupational in origin.

### HEADACHE

This is another common complaint observed in the dispensary. It may be from various causes. The usual treatment is palliative—drugs used to be selected by plant physician.

**Treatment:**

1. Give a mild analgesic in sufficient quantity to enable the person to finish the day's shift. If relief is not achieved, the patient must be advised to see his doctor, or the plant physician if an occupational background is suspected.

### PAINFUL FEET

Bases of such complaints are usually either traumatic, infectious or structural deformities. If traumatic, refer case to plant physician, unless the injury is very slight. If infectious, refer to plant physician for disposition or further orders. If a static deformity is encountered such as flattening of the arches, bunions, or ingrown nails the patient should be referred to his physician. The patient will usually be relieved by rest and elevation of the foot regardless of the etiological factor.

### PALPITATION

Palpitation usually results from fatigue or emotional disturbance. It is seldom primarily of serious importance. However, it can be very annoying or frightening to the patient.

**Treatment:**

1. Put patient at rest in a position most comfortable to him.

2. Give a mild sedative for temporary relief.
3. If the complaint is not readily relieved, call plant physician.
4. Refer patient to his private physician for further study and care.

### VERTIGO AND FAINTING

Vertigo and fainting, if associated with trauma to the head, may indicate intracranial injury. Careful inquiry should be made as to the history of injury. If it is thought that trauma to the head is a factor, treatment should be:

1. Put patient at bed rest.
2. Call plant physician.
3. Take and record temperature, pulse, respiration and blood pressure at half hour intervals until further directed by plant physician.

If not associated with trauma, this condition may indicate a vascular disturbance or some temporary physiological imbalance. Treatment should be the same as if there had been an injury. The patient should be referred to his doctor for diagnostic procedure and further care.

### SECTION 3

#### Objective Findings

Some of the most significant factors in a case may not be recognized by the patient but may be readily seen upon examination. Some of these common objective symptoms are:

#### CYANOSIS

Cyanosis usually results from cardiac disease impairing circulation, pulmonary disease, bronchial obstruction, or some intoxicant disturbing the blood oxygen carrying mechanism.

**Treatment:**

1. Call plant physician.
2. Supply oxygen for symptomatic relief, if severe.
3. Observe temperature, pulse, respiration and blood pressure and record.

#### ECCHYMOSIS

Ecchymosis results from the deposition of the blood into the tissue spaces. It usually results from simple direct trauma. It can also result from chemical toxicity or some blood dyscrasia with disturbance of blood clotting.

**Treatment: (Acute trauma)**

1. Apply a cold compress with pressure as tolerated.
2. Use analgesics for pain as indicated.
3. After about forty-eight hours, warm compresses or hot soaks.

**Treatment: (Nontraumatic)**

This seldom demands emergency treatment. The extent and degree should be noted and careful inquiry made as to onset and course. If severe or rapidly progressing, the patient should be seen at once by the plant physician.

#### ERYTHEMA—(Not due to trauma)

Erythema as a finding alone is seldom of serious importance. It represents a capillary dilatation and



when limited in extent it is due to some local dysfunction of the capillary walls or is a manifestation of local vasomotor disturbance. When general, it indicates some systemic toxicity or general vasomotor disturbance.

**Treatment:** Refer to the plant physician to determine the cause, and for further disposition.

#### EYES—Inflammation—not traumatic

The nurse should carefully wash her hands before any eye examination; make certain that all instruments, applicators and patches used are sterile. She must be particularly careful and gentle at all times. No eye has been thoroughly examined if a good light has not been used and if the eye has not been carefully inspected over all areas, with the aid of a loupe. Both lids should be turned. After treatment, or examination, the nurse should then again carefully wash her hands and sterilize all instruments. Eyes are the most delicate structures which the industrial nurse will be called upon to treat. The action taken for the severe cases will be based on severity and progress of the condition.

#### **Treatment:**

1. For the mild inflammatory reactions irrigate with boric acid solution, follow this with the ophthalmic medication recommended by the plant physician.
2. If the eye is particularly painful, use a mild ophthalmic anesthetic such as Holocaine, Butyn or Procaine as a single dose and apply an eye patch.
3. When an eye patch is applied, the patient should be advised as to his loss of accommodation, and not be permitted to resume work around moving machinery, or to operate mobile equipment.
4. If problem is nonindustrial, refer to private physician for further care.

#### EYES—Injuries:

Eye injuries often simulate inflammatory reactions. Frequently the nurse in industry will see what is thought to be a foreign body in the eye which is really an inflammatory reaction of non-industrial origin. The above recommended procedures as to cleanliness and care should be followed in examination of the eye.

#### **Treatment:**

1. If a loose foreign body is seen in the eye and can be gently removed with a swab saturated with boric acid solution with or without an anesthetic, the nurse should do this, otherwise refer to plant physician.
2. If necessary, a few drops of ophthalmic anesthetic may be used. This will greatly facilitate an accurate examination.
3. If, upon examination, a severe injury is seen such as a laceration of the cornea or penetration of the ocular bulb, the eye should be immediately put at rest with an eye patch, an ice cap applied, and the patient put at rest until he can be seen by the physician.

**Note:** In those plants where acids or caustics or other irritating substances are used, emergency eye washing apparatus to dispense copious quantities of water should be installed for immediate emergency use in the operating department.

#### DERMATITIS

Dermatitis is one of the common complaints of the industrial worker. It seldom demands emergency care and its effective treatment is dependent upon a careful study of the dermatitis as to type, course, distribution and etiology. Prevention is the most important phase in the control of dermatitis.

Careful consideration must be given as to whether the dermatitis appears to be a manifestation of some systemic disease or appears to be occupational. If it is a contact manifestation, then it may safely be treated systematically as follows:

1. Refer all cases to plant physician for diagnosis first.
2. For a dry inflammatory skin, use a bland lotion or ointment as prescribed by the plant physician.
3. For the exfoliative or weeping areas, use a bland solution with astringent action such as Burrows solution 1:4 as prescribed by the plant physician.
4. Continue observation to note the course.

#### DISTORTION OF NORMAL CONTOUR

Distortion of normal contour may result from new growth, congenital deformity, edema, fractures, dislocations, etc. A careful history of the duration and onset is of prime importance. If it follows trauma, gentle compression and immobilization should be done at once and then proceed with further observation and diagnosis by physician.

#### HEMORRHAGE

Hemorrhage is one of the most spectacular, hence one of the most exciting emergencies. It is always desirable to avoid any serious blood loss, however, the method of prevention has to be consistent with the location and extent of the wound.

#### **Treatment:**

1. Apply pressure to bleeding point, or pressure over supplying artery to the wound. A tourniquet may be used if recommended by plant physician. A tourniquet should be tight enough to control bleeding, and should be left on for a designated time as directed by plant physician.
2. Forceful bleeding points may be grasped with a hemostat which should be left in place until the doctor arrives.
3. Control diffuse or capillary bleeding by thorough cleansing followed by application of a sterile dressing and gentle compression.
4. Control nose bleed by any or all of the following methods:
  - (a) Cold compresses over nose, with rest.
  - (b) Vasoconstrictor nose drops in the nostril.

- (c) Packing of the nostril with gauze soaked in medication as directed by the plant physician.
- 5. Control internal hemorrhage:
  - (a) Call doctor immediately.
  - (b) Put patient at rest.
  - (c) Apply pressure or ice cap over area if tolerated.
  - (d) Give particular attention to general condition of patient and record temperature, pulse, respiration and blood pressure at half-hour intervals.

#### HYPERTENSION AND HYPOTENSION

Variations in blood pressure beyond the normal range may produce distressing and dangerous situations.

*Hypotension:* May follow extreme fatigue, toxicity, emotional disturbance or depressant drugs. It will probably cause the patient to complain of vertigo, headache, visual disturbance or syncope.

Treatment:

1. Put patient flat in bed or with head dependent. Record pressure.
2. Give a mild stimulant by inhalation, e.g., aromatic ammonia or other medication as directed by the plant physician.
3. If hypotension is extreme, persistent or repeated, refer to the plant physician.

*Hypertension:* May result from stimulation but usually is a long standing disorder. It may cause the patient to complain of vertigo, a throbbing headache, and visual or auditory disturbances.

Treatment:

1. Put patient at rest. Record blood pressure.
2. Administer a mild sedative as directed by plant physician.
3. Give vasodilators such as inhalation of Amyl Nitrate cautiously and on advice of a physician.
4. If persistent and severe, refer to plant physician.

#### JAUNDICE

Jaundice, though alarming, will seldom need any emergency treatment. The nurse should be alert to the possibility that jaundice may be due to absorption of toxic substances. Patient should be referred to plant physician for diagnosis and disposition of the case.

#### OPEN WOUNDS

This problem may vary greatly as to extent, severity and location. In general, any open wound must be carefully inspected as to structures involved. A thorough cleansing must be made, guarding carefully to prevent contamination of the wound.

Treatment:

1. Cleanse wound with warm water and soap. Other methods may be outlined by your physician.
2. If the part is particularly dirty, cover the wound with sterile dressing and clean around

it, then remove the dressing and irrigate the wound with sterile saline solution.

3. Apply topical dressings following this cleansing, and refer to plant physician. Suturing by nurses should not be done.

#### TREMOR OR STAGGERING

Tremor, staggering or other uncoordinated movements are primarily of importance because the patient may injure himself or some other employee.

Treatment:

1. Isolate, restrict activity or put this patient at rest as seems practical in his case.
2. Continue with further observation.
3. Refer to plant physician for diagnosis and treatment.

#### SECTION 4

##### Special Problems in Selected Cases

#### BURNS

Burns, as seen in industry, may come from a wide variety of agents. Their danger depends largely upon the total body surface burned and the immediate complaints will depend largely on the emotional stability of the patient. Generally, severe burns will be accompanied by extreme pain and shock.

Treatment:

1. Observe patient generally to determine extent of burn and take temperature, pulse, respiration and blood pressure and record.
2. Give sedatives and analgesics to control pain and repeat at intervals sufficient to do this as ordered by the plant physician.
3. Cleanse burned area with soap and warm water thoroughly, if at all tolerated, as directed by the plant physician. Attempt particularly to remove foreign substance such as caustics or other irritating material by copious wash or manual removal.
4. After cleansing, apply dressings as directed by the plant physician.
5. Refer all severe burns to the plant physician.

Note: Anticipate that the doctor will prescribe antitoxins, antibiotics, and plasma and have supplies at hand.

#### DOG BITE

Dog bite represents a special type of wound worthy of particular mention only because of the danger of the specific infection of rabies. Perhaps in most industries it will not be a problem, but it is a problem in those industries making house to house deliveries, e.g., grocers, bakers, dairies, postmen, and meter readers.

Treatment:

1. Cleanse the wound immediately, taking care to irrigate it thoroughly.
2. Cauterization of the wound may occasionally be indicated but this should always be determined and done by the physician.
3. Pasteur treatment may be considered and given at the discretion of the physician.
4. Notify local health authorities so that the dog



may be under observation for at least 10 days.

#### ELECTRIC SHOCK

The immediate danger of an electric shock lies in the fact that the heart action may be greatly depressed and respiration arrested. This is due to the action on the automatic nervous system. Severe local burns may result at the points of contact. The cardiac and pulmonary function is of primary importance and the burns may be ignored until these functions are established.

Treatment: If no pulse can be felt or heart beat heard—

1. Call plant physician immediately.
2. Start artificial respiration and continue until normal heart and respiratory functions are established or until advised by the physician that further effort is not indicated.
3. After resumption of cardiac function and respiration, treat the burns as directed. The electric burn will frequently penetrate deeply and tissue destruction will be greater than at first anticipated.

#### HEAT SHOCK AND HEAT STROKE

Two very definite states may develop from exposure to heat to produce diametrically opposite symptoms. Great care must be taken to be sure that the proper evaluation is made. The treatment is radically different for each state and a confusion might cause damage.

*Heat shock* or heat exhaustion is a condition which results from fatigue of the heat regulating center causing a disturbance of blood chemistry. It will be characterized by a complaint of vertigo, nausea, weakness, and abdominal and muscular cramping. The skin will be moist and cold with a rapid weak pulse and a low blood pressure. The temperature will be normal or subnormal.

Treatment:

1. Call a physician.
2. If patient is cramping or restless, give sedative as directed by the plant physician.
3. Apply hot water bottles and blankets until skin becomes warm and temperature begins to rise.
4. Give saline solution with 5% glucose intravenously or orally as directed by the plant physician.

Note: This patient will probably not tolerate salt and fluid by mouth while in this acute state.

*Heat stroke* is a state in which the heat dissipating mechanism is unable to keep the body cool. The patient will complain of being hot, perhaps a headache, with nausea and vertigo, and visual disturbances. Examination will show the patient to have a hot, dry skin, probably flushed with a circumoral pallor. The oral or rectal temperature will be greatly elevated.

Treatment should be directed to cool this patient and start him perspiring:

1. Give patient cool drinks by mouth with aspirin in doses of gr. X or XX each thirty minutes as directed by the plant physician until skin becomes moist.
2. Sponge with cold or iced water until temperature begins to fall.
3. Ice caps to head, neck and chest as tolerated or until temperature begins to fall.
4. Advise patient to avoid strenuous exertion, exposure to excessive heat, and to eat lightly for the next few days.
5. Call the plant physician for further care.

#### SECTION 5

##### Policies

Reference to a private physician can be made only upon the request of the patient. The industrial nurse may be of great service to the patient in pointing the way to good medical care, the quality of which the patient probably cannot accurately judge for himself.

The nurse should refer the patient to a physician of his choice and assist him as necessary in securing an appointment. If the patient has no choice or is not acquainted with a doctor, the nurse may then, without partiality, suggest a list of physicians whose location or type of practice meet the patient's requirements.

The nurse should understand the management's policy relative to medical absenteeism and she should strive to comply with this policy.

In her work the industrial nurse must, to a limited extent, act upon her own judgment. This action must always be tempered with caution, conservatism, accurate observation, sound scientific knowledge, and an individual consideration of the circumstances. When she is in doubt, when the patient seems noncooperative, frightened or dissatisfied, or when for any other reason the situation seems unsatisfactory, the plant physician should be called before treatment is prescribed or a definite disposition of the case is made. She must at all times strive to be aware of the emotional status of the patient, reassure him, inspire confidence, and particularly guard against expressions or insinuations of a personal or professional opinion from which the patient could project a wrong conclusion.

The industrial nurse must always retain the role of a nurse, making it clear to the patient that she is carrying out a program prescribed by the doctor, and that she is working conscientiously for the benefit and protection of the patient under the doctor's direction.

Sub-Committee on Medical Direction for the Nurse in Industry—Committee on Industrial Health—Indiana State Medical Association

E. B. Lamb, M.D., Chairman  
Allan K. Harcourt, M.D.  
Louis W. Spolyar, M.D.  
Members

## The Fourth Estate Looks At Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

### AS WE SEE IT—SUSPICIOUS AUSPICES

Dr. Gunnar Gundersen of LaCrosse, Wis., is a former president of the Wisconsin State Medical Society and a regent of the University of Wisconsin. He is better acquainted than most with the convictions of a majority of the fifteen members of the commission which President Truman has appointed to study the "health needs of the nation."

Dr. Gundersen has declined to serve on the commission. He terms it a "masquerade," packed with advocates of the President's compulsory health insurance scheme.

Honestly and fairly conducted, such a survey could be useful in suggesting policies to improve medical training, to correlate public and private health services, to get more, better and less expensive care of the sick.

Precedent, however, supports Dr. Gundersen's conclusion that Mr. Truman's interest in health is largely confined to the convalescence of his political machine. Under his auspices, the findings of the commission are discounted in advance, on the theory that he is far too cagey to risk a report that might be critical of one of his favorite vote-getting appeals.

—*Chicago Daily News.*

### IT'S 'POLITICS FIRST'

President Truman has named "a commission on the health needs of the nation." But Dr. Gunnar Gundersen, a trustee of the American Medical Association, will not be a member of it. Mr. Truman named the LaCrosse, Wis., physician to the body, along with other highly qualified medical and dental men and several laymen, some of whose qualifications are open to question. But Dr. Gun-

dersen calls the commission "an instrument of practical politics to relieve President Truman from an embarrassing position as an unsuccessful advocate of compulsory health insurance."

Perhaps Dr. Gundersen also has observed how other expert commissions have been appointed by Mr. Truman to study this or that, and how some of their findings have been ignored or used piecemeal and out of context to support demands for Fair Deal legislation or in defense of Fair Deal administrative actions.

A notable instance involved the President's Air Policy Commission, which was formed in 1947. On January 1, 1948, the group presented an excellent report. The most urgent recommendation was that an Air Force buildup to 70 groups be started at once. So what did Mr. Truman do? He impounded money appropriated for that buildup! The commission's finding didn't agree with his view, so he went ahead and did as he pleased. The expense and effort which went into determining the need for a 70-group buildup were wasted.

A similar fate has attended the monumental government reorganization report of the Hoover Commission. Parts of it have been put into effect. But other important parts have not been put into effect, for a variety of purely political reasons involving both the Truman administration and Congress.

We do not know how right Dr. Gundersen is in his charge. But the record indicates that any health report made by the new commission will in itself become "an instrument of practical politics." We suspect that what fits in with Mr. Truman's and Oscar Ewing's aims and views will be promoted and that what doesn't won't be. That's the way it seems to go in the Truman administration where "politics first" is the reigning consideration.

—*Indianapolis Star.*





# News Notes

## ANNUAL SYMPOSIUM ON THE HEART

February 5, 1952

INDIANA UNIVERSITY SCHOOL OF MEDICINE  
Indianapolis  
Sponsored By  
THE INDIANA HEART FOUNDATION  
and  
INDIANA UNIVERSITY SCHOOL OF MEDICINE

### Program

- 10:00 A.M. "Prognosis in Coronary Artery Disease"  
ROY W. SCOTT, M. D., Cleveland, O.
- 11:00 A.M. "Management of the Arrhythmias."  
T. J. DRY, M.D., Rochester, Minn.
- 12:00 Noon "Some Aspects of the Diagnosis and  
Treatment of Vascular Diseases"  
E. A. HINES, JR., M.D., Rochester, Minn.
- 1:00 P.M. Lunch
- 2:30 P.M. "Medical Management of Hypertension"  
R. W. WILKINS, M.D., Boston, Mass.
- 3:30 P.M. "Changing Concepts and Techniques in  
the Management of Heart Failure"  
C. K. FRIEDBERG, M.D., N. Y., N. Y.
- 8:00 P.M. Round Table Discussion, KENNETH G.  
KOHLSTAEDT, M.D., Moderator  
Speakers will participate  
This round table will constitute the  
Telephone Postgraduate Program  
for the month of February.

Program is open without registration to all  
physicians of the state.

The Fifth American Congress on Obstetrics and  
Gynecology will be held in Cincinnati, Ohio, March  
31 through April 4, 1952, at the Netherland Plaza  
Hotel.

Sponsored by the American Committee on Ma-  
ternal Welfare, the Congress will feature a com-  
prehensive five-day scientific program covering the  
medical, nursing and public health aspects of the  
maternal care team.

Congress registration fees are \$5.00 for members  
and \$10.00 for non-members. Further information,  
registration or reservations can be obtained by  
writing to Mr. Donald F. Richardson, Executive  
Secretary, American Committee on Maternal Wel-  
fare, 116 South Michigan, Chicago 3, Illinois.

## ARMED FORCES SURGEONS GENERAL ACCLAIMED

In recognition of the magnificent achievements  
of the medical services of the armed forces, the  
American Pharmaceutical Manufacturers Associa-  
tion has presented its 1951 Scientific Award to the  
Surgeons General of the U. S. Army, Navy and  
Air Force. Recipients of the award were Major  
General George E. Armstrong, USA; Rear Ad-  
miral H. Lamont Pugh, USN, and Major General  
Harry G. Armstrong, USAF. The awards were  
presented by Dr. Martin Lasersohn, chairman of  
the Association's Awards Committee, at the A. P.  
M. A.'s mid-year meeting at the Hotel Waldorf-  
Astoria.

## UNIVERSITY OF MICHIGAN MEDICAL SCHOOL The Department of Postgraduate Medicine

Brief Review Courses for Practicing Physicians

1952

### Internal Medicine

Diseases of the Heart	March 17-21
Rheumatic Diseases	March 24-28
Metabolism and Endocrinology	March 31-April 4
Diseases of the Blood and Blood-Forming Organs	April 7-11
Diseases of Gastro-Intestinal Tract	April 14-18
Recent Advances in Therapeutics	April 28-30
Allergy	April 5-9
Electrocardiographic Diagnosis	August 25-30
Neurology, Clinical	May 5-9
Obstetrics and Gynecology—	
Obstetrics	January 9-12
Gynecology	February 6-9
Ophthalmology	April 21-23
Roentgenology, Diagnostic	April 7-11
Summer Session	June 23-August 2

Further information and application blanks may  
be obtained from Dr. H. H. Cummings, Chairman,  
Department of Postgraduate Medicine, University  
Hospital, Ann Arbor, Michigan.

## DOCTORS FOR SUMMER CAMPS

The Physicians Placement Service of the A.M.A.  
announces that doctors who are interested in four  
or eight week periods of work in summer camps in  
Illinois, Indiana, Michigan, Minnesota and Wiscon-  
sin may obtain information and application blanks  
by writing Camp Counselor Referral Bureau, Chi-  
cago Camping Association, 1 North State Street,  
Chicago 2, Illinois.

A Summer Camp for Diabetic Children will be  
opened for the fourth season under the auspices  
of The Chicago Diabetes Association, from July 1,  
1952, to July 22, 1952, at Holiday Home, Lake Ge-  
neva, Wisconsin.

Applications may be obtained from, and in-  
quiries should be addressed to: Chicago Diabetes  
Association, 110 South Dearborn Street, Chicago 3,  
Illinois.

The twenty-fifth annual meeting of the **National Conference on Medical Service** will be held Sunday, February 10, in the Red Lacquer Room of the Palmer House in Chicago. The conference is open to all physicians. Dr. C. A. Nafe, of Indianapolis, is a member of the Executive Committee.

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Dr. J. Hal Doran, a 1945 graduate of the Indiana University School of Medicine, has announced the establishment of his office at 720 Hume Mansur Building, Indianapolis, for the practice of internal medicine with special reference to diseases of the heart. Doctor Doran will be in association with Dr. Arthur B. Richter at that address.

Doctor Doran served his internship at St. Vincent's Hospital and then took additional postgraduate training in Cleveland's Glenville Hospital and at St. Vincent's Hospital, Indianapolis. He is a veteran with two years service.

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Dr. Kenneth L. Craft, of Indianapolis, was on the program of the Kansas City Eye, Ear, Nose and Throat Society, in November. He spoke on "Allergy of the Upper Respiratory Tract," and "Allergy of the Skin as Seen by the Otolaryngologist."

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Harold N. Johantgen, M.D., former resident in medicine and cardiology, has been appointed director of the newly-established Student-Employee Health Service on the Indiana University Medical Center campus in Indianapolis.

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Dr. F. R. N. Carter, of South Bend, addressed the Hawaiian Public Health Association in November at Honolulu. Doctor Carter spoke on the development of the program on chronic illness in Indiana.

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Dr. Benjamin M. Kohrman of Michigan City and Dr. Eugene J. DeGrazia of Valparaiso attended postgraduate courses at the Cook County Graduate School of Medicine in December.

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Samuel R. Damon, Ph.D., director of the Bureau of Laboratories, Indiana State Board of Health, was selected chairman of the Conference of State and Provincial Public Health Laboratory Directors of North America, at the annual conference of the association held prior to the meeting of the American Public Health Association in San Francisco, California. He succeeds Dr. A. V. Hardy, director of the Bureau of Laboratories, Florida State Department of Health.

Dr. Damon was also selected chairman of a new organization formed at the meeting with membership limited to the directors of state and territorial public health laboratories. This organization is to be known as The Association of State and Territorial Public Health Laboratory Directors.

The Cancer Cytology Center of the Dade County Cancer Institute, Miami, Florida, announces its second one-week seminar for physicians to be held at the Institute from April 21st-25th.

Interested physicians should direct their inquiries regarding qualifications, registration, fees and other details to the Director of the Dade County Cancer Institute at 1155 North West 14th Street, Miami, Florida.

Applications for registration, limited to 35 physicians, will be accepted through April 19th.

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Dr. Derrick T. Vail, professor and chairman of the Department of Ophthalmology at Northwestern University, will become chairman of the Special Medical Advisory Group of the Veterans Administration in January, 1952, VA announced.

Dr. Vail will succeed Dr. Charles W. Mayo of the Mayo Clinic at Rochester, Minnesota, who has been chairman of the Group since it was organized six years ago. Dr. Mayo will continue as a member of the Group.

Other new officers of the Group are Dr. Franklin D. Murphy, chancellor of the University of Kansas, vice chairman, and Dr. Brian B. Blades, professor of surgery at George Washington University, secretary.

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Dr. William Cripe has taken over the office of Dr. F. E. Keeling in Portland. Doctor Keeling has returned to military service, and will be stationed in Germany. Doctor Cripe has been practicing in Redkey.

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Dr. David L. Lutes, of Bloomington, has opened an office in Wheatland for the practice of medicine.

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Dr. J. E. Hull, of Indianapolis, has been appointed research fellow in surgery for 1952-1953 by the Charles J. Wolf Foundation for Medical Research at Indianapolis General Hospital.

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Dr. Harold L. Fosgate, a 1950 graduate of Indiana University School of Medicine, has opened an office for general practice at 2123 West Washington Street in Indianapolis.

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Dr. Frances T. Brown, of Indianapolis, attended a meeting of the Medical Women's International Alliance in Montevideo, South America, in December. While making a tour of South American countries, Doctor Brown visited the former Dr. Mary Alice Norris in Rio.

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Dr. Bennett Kraft, of Indianapolis, recently attended the First International Congress of Allergy in Zurich, Switzerland.



## *Indiana University News Notes*

Dr. Charles A. Doan, dean of the School of Medicine of Ohio State University, will speak at 8 p.m., on February 29, in the auditorium of the Medical School. This will be the annual Burton D. Myers lecture, sponsored by the Nu Sigma Nu fraternity. Doctor Doan's subject will be "Management of Hemolytic Anemias." Doctor Doan is considered an authority on blood. The meeting is open to all physicians.

Approximately 5,000 miles of long-distance telephone wires were put into use for the third in the current series of Telephone Seminars presented in the Auditorium of the Medical School. The program on "The Newer Aspects of the Diagnosis and Treatment of Tuberculosis" was presented by the School of Medicine and the Indiana State Medical Association with the cooperation of the Indiana Tuberculosis Association.

Dr. William Province of Franklin, vice-president of the tuberculosis organization in the state, was moderator for the program which included Dr. John H. Skavlem, president of the American Trudeau Society and Associate Professor of Medicine at the University of Cincinnati, who spoke from Cincinnati; Dr. Julius L. Wilson, Professor of Clinical Medicine at Tulane University and a member of the Study Section on Experimental Therapeutics of the U. S. Public Health Service, speaking from New Orleans; and Dr. Herbert L. Mantz, director of Clinics and Tuberculosis Control for the Kansas City Health Department, was heard from Kansas City. The program was heard by approximately 20 county medical societies throughout the state.

Dr. Harris B. Shumacker has returned from Korea where he served as a consultant to the Surgeon General's office on treatment of frostbite among the UN forces.

Members of Lions Clubs of Indiana attended an "Open House" held in the Department of Radiology on December 2. State officers of the Lions and trustees of the Lions Club Cancer Control Fund were guests at a luncheon preceding the afternoon program.

The affair was arranged in recognition of the activity of Hoosier Lions in underwriting the purchase of x-ray equipment, including the million-volt unit. The clubs pledged \$50,000 to equip the department and approximately \$42,000 of that amount has been paid.

Two members of the Medical School staff recently resigned to accept positions elsewhere. Dr. Versa V. Cole, Associate Professor of Pharmacology since 1944, accepted an appointment to the Department of Pharmacology at the Army Medical Center, Belle Air, Maryland. She held an M.S. degree from Kalamazoo College, and Ph.D. and M.D. degrees from the University of Chicago.

Dr. Philip F. D. Seitz, director of Psychiatric Research, has received renewals of grants made by the U. S. Public Health Service for studies in the field of psychiatry.

Christmas and the holiday season brought many visitors to the Medical Center campus. Several Indianapolis organizations sang carols in the University hospitals and Santa Claus, sponsored by the Riley Cheer Guild, presented gifts to all the patients during the holiday affairs. Judy Perkins and Ernie, WLW Radio Station stars, were highlights of the annual Riley Cheer Guild-WLW Christmas party held in Riley Hospital for the children.

Not only were the children and patients remembered but every one enjoyed the Annual All-Campus Christmas party on December 20 from 3 to 6 p.m. in Hurty Hall of the Laboratory Science Building. The visiting staff as well as all the campus staff and personnel were invited to attend the affair.

## A.M.A. WASHINGTON OFFICE NEWS

## PRESIDENT'S STATE OF THE UNION MESSAGE

The President on January 9 read to a joint session of the House and Senate a nine-page State of the Union message. Following are quotations pertaining to medical legislation:

"I think everybody knows that social insurance and better schools and health services are not frills, but necessities in helping all Americans to be useful and productive citizens, who can contribute their full share in the national effort to protect and advance our way of life.

"We urgently need to train more doctors and other health personnel, through aid to medical education. We also urgently need to expand the basic public health services in our home communities—especially in defense areas. The Congress should go ahead with these two measures immediately.

"I have set up an impartial commission to make a thorough study of the Nation's health needs. One of the things this commission is looking into is how to bring the cost of modern medical care within the reach of all our people. I have repeatedly recommended national health insurance as the best way to do this. So far as I know, it is still the best way. If there are any better answers, I hope this commission will find them. But of one thing I am sure: something must be done—and be done soon."

Meanwhile, the Commission has started on its task, under the direction of Dr. Paul Magnuson. At the group's first meeting, Dr. Magnuson announced that the Commission staff would be supervised by Dr. H. A. Press, who was closely associated with Dr. Magnuson when the latter was head of the Veterans Administration's Department of Medicine and Surgery. Dr. Press is taking a leave of absence from the Veterans Administration, where he has been serving as Director of Program Analysis in the medical department. Several other staff appointments will be announced shortly. Although the survey originally was scheduled for completion in about a year, Dr. Magnuson says he now thinks more time may be needed. He expects shortly to announce appointment of another physician to the Commission to fill the place left vacant by the resignation of Dr. Gunnar Gunderson, A.M.A. Trustee. The Commission includes labor, farm, and consumer members, as well as representatives of the health professions.

**VA Redefines Rules on Domiciliary Care and Insurance Recovery.** Veterans Administration regulations, revised to conform with new laws, also redefine procedures for recovering medical care costs from insurance companies and for the first time set a dollar-and-cents standard for determining when a veteran has "no adequate means of support." The new regulations, printed in the Federal Register of November 30, include:

1. When a non-service connected case applies for free domiciliary (*not hospital*) care, claiming "no adequate means of support," an income of \$125 per month is the cutoff point for a man with no dependents. If income is under that, he is eligible; if above, he is not. However, if the patient is contributing *in whole or in part* to the support of a wife, child, mother or father, the \$125 limitation does not apply.

Rules governing *non-service connected admissions to VA hospitals* remain virtually unchanged. The veteran still must affirm he is unable to pay for hospitalization, and VA still may not investigate beyond the statement.

2. VA reaffirms its intention to recover money from obligated third parties for medical care rendered to veterans. This long-standing policy has been enforced with varying success. It is aimed at collecting from health and hospital insurance companies, from union welfare funds, from public and private compensation funds, from legally liable persons (as in accident cases) and from other federal departments.

On this point, the regulation states that veterans "who it is believed may be entitled to hospital care or medical or surgical treatment or reimbursement for all or part of the cost, by reason of statutory, contracted or other relationships with third parties . . . will not be furnished hospital treatment without charge . . . to the extent of the amount for which third parties are liable."

The regulations explain in detail how hospital administrators are to proceed to make collections from such third parties.

**FSA Undecided on Using Voluntary Plans for Hospitalization of Aged.** Federal Security officials are considering revising the proposed plan for hospitalization of the aged to *bring them under voluntary health plans*, with the federal government paying premiums. Among difficulties is the fact Blue Cross and other plans vary in benefits and a federal program would have to be fairly uniform. Although the subject has been under discussion for almost a year, no legislation has been introduced.



## *Society Reports*

### INDIANA STATE MEDICAL ASSOCIATION

#### COUNTY MEDICAL SOCIETY OFFICERS

#### CARROLL COUNTY MEDICAL SOCIETY

President, Max Adams, Flora  
Vice-President, George W. Wagoner, Delphi  
Secretary-Treasurer, Thomas C. Brown, Delphi

#### CLAY COUNTY MEDICAL SOCIETY

President, R. K. Webster, Brazil  
Vice-President, Charles Moon, Center Point  
Secretary-Treasurer, John Palm, Brazil

#### DEARBORN-OHIO COUNTY MEDICAL SOCIETY

President, Fred D. Houston, Lawrenceburg  
Vice-President, O. H. Stewart, Aurora  
Secretary, Charles N. Manley, Rising Sun  
Treasurer, J. M. Pfeifer, Lawrenceburg

#### DELAWARE-BLACKFORD COUNTY MEDICAL SOCIETY

President, Joseph H. Clevenger, Muncie  
Secretary, Thomas M. Brown, Muncie  
Treasurer, Milton Gustafson, Muncie

#### FAYETTE-FRANKLIN COUNTY MEDICAL SOCIETY

President, Frank H. Neukamp, Connersville  
Vice-President, H. N. Smith, Brookville  
Secretary-Treasurer, A. F. Gregg, Connersville

#### FOUNTAIN-WARREN COUNTY MEDICAL SOCIETY

President, Carl A. Freed, Attica  
Vice-President, Carl A. Nelson, West Lebanon  
Secretary-Treasurer, T. Tom Suzuki, Covington

#### HUNTINGTON COUNTY MEDICAL SOCIETY

President, T. W. Omstead, Huntington  
Vice-President, R. D. Meiser, Huntington  
Secretary-Treasurer, Stanton Cope, Huntington

#### JASPER-NEWTON COUNTY MEDICAL SOCIETY

President, L. E. Kresler, Rensselaer  
Secretary-Treasurer, E. R. Beaver, Rensselaer

#### KNOX COUNTY MEDICAL SOCIETY

President, N. M. Welch, Vincennes  
Vice-President, J. E. Humphreys, Vincennes  
Secretary-Treasurer, R. O. Smith, Vincennes

#### LAWRENCE COUNTY MEDICAL SOCIETY

President, D. M. Kerr, Bedford  
Vice-President, James Oswalt, Mitchell  
Secretary-Treasurer, L. E. Benham, Bedford

#### MARION COUNTY (Indianapolis) MEDICAL SOCIETY

President, Glen V. Ryan, Indianapolis  
President-Elect, H. C. Ochsner, Indianapolis  
Vice-President, R. D. Howell, Indianapolis  
Secretary-Treasurer, R. M. Hansell, Indianapolis

#### MORGAN COUNTY MEDICAL SOCIETY

President, Kenneth Comer, Mooresville  
Secretary-Treasurer, Ray D. Miller, Martinsville

#### PARKE-VERMILLION COUNTY MEDICAL SOCIETY

President, E. H. Dowell, Rockville  
Secretary-Treasurer, N. B. Rosenfeld, Clinton

#### PERRY COUNTY MEDICAL SOCIETY

President, David Dukes, Tell City  
Vice-President, Fred Glenn, Tell City  
Secretary-Treasurer, Donald Lashley, Tell City

#### PIKE COUNTY MEDICAL SOCIETY

President, M. H. Omstead, Petersburg  
Vice-President, J. T. Kime, Petersburg  
Secretary-Treasurer, J. L. Higgins, Petersburg

#### PORTER COUNTY MEDICAL SOCIETY

President, Ralph C. Eades, Valparaiso  
Vice-President, C. M. Harless, Chesterton  
Secretary-Treasurer, J. R. Frank, Valparaiso

#### RANDOLPH COUNTY MEDICAL SOCIETY

President, C. R. Slick, Lynn  
Vice-President, Harvey White, Farmland  
Secretary-Treasurer, R. M. Potter, Ridgeville

#### RIPLEY COUNTY MEDICAL SOCIETY

President, R. Lee Smith, Osgood  
Secretary-Treasurer, Henry W. Conrad, Milan

#### RUSH COUNTY MEDICAL SOCIETY

President, R. O. Kennedy, Rushville  
Vice-President, Roy E. Shanks, Rushville  
Secretary-Treasurer, E. M. Truman, Rushville

#### TIPPECANOE COUNTY MEDICAL SOCIETY

President, Ira Cole, Lafayette  
Vice-President, Lowell C. Smith, Lafayette  
Secretary, Hugh B. McAdams, Lafayette  
Treasurer, R. W. Vermilya, Lafayette

#### TIPTON COUNTY MEDICAL SOCIETY

President, Jean V. Carter, Tipton  
Vice-President, S. M. Cotton, Goldsmith  
Secretary-Treasurer, William Kurtz, Tipton

#### WAYNE-UNION COUNTY MEDICAL SOCIETY

President, Paul G. Hill, Cambridge City  
Vice-President, Frank H. Coble, Richmond  
Secretary-Treasurer, Paul W. Runge, Richmond

#### WELLS COUNTY MEDICAL SOCIETY

President, Thomas O. Dorrance, Bluffton  
Vice-President, Homer B. Annis, Bluffton  
Secretary-Treasurer, Jack L. Eisaman, Bluffton

**LOCAL SOCIETY REPORTS**

**Boone County Medical Society** members met at the Witham Memorial Hospital in Lebanon on December 2, for the telephone seminar.

**Carroll County Medical Society** members met at Friendship House in Delphi on December 19. This was a business meeting, and thirteen members were present to elect officers for 1952.

**Clay County Medical Society** members met at the Elks Club in Brazil on December 18. Seven members were present for the election of officers.

**Dubois County Medical Society** members met at the Dubois County Memorial Hospital on December 13. Glenn W. Irwin, Jr., of Indianapolis, was the guest speaker. His subject was "Cortisone and ACTH." Eighteen members were present.

**Floyd County Medical Society** members met at the Colonial Manor in New Albany on December 15. This was the annual Christmas party, and forty-two members and their wives were present.

**Huntington County Medical Society** members met at the Hotel LaFontaine in Huntington on November 6. The guest speakers were Drs. George R. Horton and Charles J. Cooney, of Fort Wayne, whose subject was "Traumatic Genito-urinary Injuries." Twenty members were present.

Another meeting was held on December 4, when the eighteen members present held election of officers.

**Jasper-Newton County Medical Society** members met with members of the Woman's Auxiliary at the Brook Hotel in Brook on December 12. Drs. Hedwig and Hugh Kuhn, of Hammond, presented a talk on their trip to Africa, also showing colored slides. Election of officers for 1952 was held.

**Lawrence County Medical Society** members met at the Dunn Memorial Hospital in Bedford on December 12. Sixteen members were present for election of officers and participation in the telephone seminar.

**Parke-Vermillion County Medical Society** members met at Clinton on December 19. Dr. Charles Fisch, of Indianapolis, was the guest speaker. His subject was "Pericarditis." Twelve members were present.

**Porter County Medical Society** members met at the Lembke Hotel in Valparaiso on December 8. This was a business meeting, for the election of officers, and ten members were present.

**Ripley County Medical Society** members met at the Court House in Versailles on December 11. Officers for 1952 were elected. Four members were present.

**Tippecanoe County Medical Society** members held a meeting at Lincoln Lodge in Lafayette on December 11. Fifty members were present for the annual business meeting and election of officers.

**Wayne-Union County Medical Society** members met at Reid Memorial Hospital in Richmond on December 13. Thirty-five members were present for the annual election of officers.

**Fountain-Warren County Medical Society** members met in Covington on December 6. Twelve members were present for election of officers for 1952.

Important messages are presented in the advertisements in **THE JOURNAL** each month. New products are announced from time to time, and information is presented regarding the use of products featured. Other types of ads emphasize services rendered and commodities offered that may be used in your practice, in your office, and in your home. Please tell the advertisers that you saw their ads in **THE JOURNAL** of the Indiana State Medical Association.





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## Books

Books received are acknowledged in this column, and such acknowledgment must be regarded as a sufficient return for the courtesy of the sender. Selections will be made for more extensive review in the interests of our readers and as space permits. Books listed in this department are not available for lending. Any information concerning them will be supplied on request.

### THE SPECIALITIES IN GENERAL PRACTICE.

Edited by Russell L. Cecil, M.D., Professor of Clinical Medicine, Emeritus, Cornell University Medical College, New York City. 818 pages with 470 figures. Price \$14.50. W. B. Saunders Company, Philadelphia 5, Pa., 1951.

### PSYCHOSOMATIC GYNECOLOGY: Including Problems

of Obstetrical Care. By William S. Kroger, M.D., Assistant Clinical Professor of Obstetrics and Gynecology, Chicago Medical School; and S. Charles Freed, M.D., Adjunct in Medicine, Mount Zion Hospital, San Francisco, California. 503 pages, price \$8.00. W. B. Saunders Company, Philadelphia 5, Pa., 1951.

### BIOLOGICAL ANTAGONISM. The Theory of Bio-

logical Relativity. By Gustav J. Martin, Sc.D., Research Director The National Drug Company. Philadelphia, Pa. 516 pages, 64 figures and 44 tables. Price \$8.50. The Blakiston Company, Philadelphia 5, Pa. 1951.

### PENICILLIN DECADE, 1941-1951.

By Lawrence Weld Smith, M.D., Medical Director Commercial Solvents Corporation, and Ann Dolan Walker, R.N., Former Editor "Trained Nurse and Hospital Review." 122 pages. Price \$2.50. The Arundel Press, Inc., Washington 13, D. C., 1951.

### THE BATTLE FOR MENTAL HEALTH.

By James Clark Moloney, M.D., 105 pages; price \$3.50. The Philosophical Library, Inc., 15 East 40th Street, New York 16, N. Y., 1952.

### REHABILITATION NURSING.

By Alice B. Morrissey, B.D., R.N., Instructor in Rehabilitation Nursing, New York University-Bellevue Medical Center; Supervisor of Nursing Service, Department of Physical Medicine and Rehabilitation, Bellevue Hospital. 299 pages, 58 illustrations. Price \$5.00. G. P. Putnam's Sons, 210 Madison Avenue, New York City, 1951.

### PHYSICAL MEDICINE AND REHABILITATION FOR

THE CLINICIAN. Edited by Frank H. Krusen, M.D., Professor of Physical Medicine, Mayo Foundation and Consultant in Pediatrics, Mayo Clinic, Rochester, Minn. 371 pages and numerous illustrations. Price \$6.50. W. B. Saunders Company, Philadelphia 5, Pa., 1951.

### ANTIBIOTIC THERAPY.

By Henry Welch, Ph.D., Director; and Charles N. Lewis, M.D., Medical Officer; Division of Antibiotics, Food and Drug Administration, Federal Security Agency of the United States Government. 562 pages, numerous figures; price \$10.00. The Arundel Press, Inc., P. O. Box 2606, Washington 13, D. C., 1951.

### TEXTBOOK OF REFRACTION.

By Edwin Forbes Tait, M.D., Associate Professor of Ophthalmology, Temple University School of Medicine, and Attending Surgeon (Ophthalmology) Temple University and Montgomery Hospitals. 418 pages with 93 figures. Price \$8.00. W. B. Saunders Company, Philadelphia 5, Pa., 1951.

### HOW TO IMPROVE YOUR SEXUAL RELATIONS.

By Edwin W. Hirsch, M.D., Noted Urologist and Associate Editor, International Journal of Sexology. 64 pages, cross-indexed for quick reference, booklet is written in lay language for prescription by doctors only. Price special for first edition \$1.00 for 2 copies. Zeco Publishing Co., 327 W. Madison Street, Chicago 6, Ill., 1951.

### ANNUAL REPORT ON STRESS (1951).

By Hans Selye, M.D., Professor and Director of the Institut de Médecine et de Chirurgie expérimentales Université de Montréal. 511 pages and 133 reference pages; also numerous illustrations, drawings and charts. Price \$10.00 plus postage, 34 cents. Acta, Inc., Medical Publishers, 5465 Décarie Blvd., Montreal, Canada, 1951.

### LET'S HAVE HEALTHY CHILDREN.

By Adelle Davis, M.S., former dietitian at Bellevue Hospital, New York City, and supervisor of Health Education in public schools at Yonkers, N. Y., now a consulting nutritionist in Los Angeles. 314 Pages, including table of food analysis. Price \$3.00. Harcourt, Brace and Company, Inc., 383 Madison Avenue, New York 17, N. Y., 1951.

The importance of nutrition is frequently overlooked in every branch of medical practice. It is common practice for the physician to assume that every patient is receiving an adequate diet when in reality the complaints of many patients may be the direct result of faulty nutrition. Although the author has written this book primarily as a diet guide for mothers and not a medical text, most physicians could obtain much useful information from reading it.

Nutrition before pregnancy and during the prenatal period are discussed, as well as the nutrition of infants and older children. At the end of the book there are several pages of food analysis, which is presented so clearly that it can be understood by the average mother. The entire book is very readable and the material is impressively presented. As important as adequate nutrition is to health, the author becomes over enthusiastic when discussing some subject and at times facts are sacrificed for color. The average reader would get the impression that pregnancy toxemia could be entirely prevented or controlled by diet alone. The author strongly advocates breast feeding and has some good ideas on the subject, but is somewhat more enthusiastic than most pediatricians, by implying that all mothers can nurse their infants as they attempted to do over fifty years ago. Infant mortality then and now should be considered.

The material in this book is clearly presented and is of such importance it could be read with profit by every expectant mother. It makes a valuable supplement to routine prenatal care.

D. A. B.




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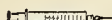
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## BOOKS REVIEWED

**THE EXCEPTIONAL CHILD.** Proceedings of a special conference between members of the press and a panel of authorities under the auspices of the Child Research Clinic of The Woods Schools, Langhorne, Pa., held March 29, 1951, at The Hotel Pierre, New York City. Copies free from the Clinic.

This pamphlet contains the proceedings of a panel discussion by a group of recognized authorities on the mentally incapable child. The conference was sponsored by the Woods Schools of Langhorne, Pa., a private school for exceptional children. The ideas expressed by the panel members were the need for early recognition and appraisal of the capabilities of the mentally handicapped child, and direction of their education and development along lines consistent with their abilities. It was also pointed out that parents and the general public should realize the problem for which there is no magic solution and that time, energy and money should not be wasted in an endless quest from one specialist to another.

These discussions should interest all parents, teachers and physicians who deal with the problem. The book can be obtained without cost from the Woods Schools.

D.A.B.

**PRACTICAL CLINICAL PSYCHIATRY.** Seventh Edition. By Edward A. Strecker, M.D., School of Medicine, University of Pennsylvania; Franklin G. Ebaugh, M.D., University of Colorado, School of Medicine; and Jack R. Ewalt, M.D., University of Texas Medical Branch. 506 pages with 35 figures and 14 tables. Price \$7.00. The Blakiston Company, 1012 Walnut Street, Philadelphia 5, Pa., 1951.

This is the seventh edition of this well-known textbook on clinical psychiatry. In it the authors have recognized the import of the ever increasing numbers of patients mentally and emotionally ill and the still inadequate number of physicians trained to treat these patients. This book is written for the general man in the practice of medicine, who must of necessity interview and attempt to treat the vast majority of these sick people.

The reader is oriented in the opening chapters to the basic concepts in personality development and function, the methods of psychiatric examination, the manner of recording findings, and the classifying of conditions. He becomes acquainted with the terminology necessary to clear thinking in the language of the psychiatrist.

The midsection of the book deals with the various psychopathological states, each being discussed as to etiology, incidence, tissue pathology, psychopathology and symptomatology, prognosis, and treatment. Case histories are included throughout to illustrate the basic principles, and each chapter has references for additional reading.

Psychosomatic medicine, the psychoneuroses, and pathologic drinking are given special consideration. The discussion on "support" psychotherapy in chapter 13, alone, makes this book most worthwhile. In it the authors outline the techniques of treating patients who certainly need help, but perhaps not to the degree of extensive orthodox psychoanalytic procedures.

Dr. Leo Kanner's style of presentation, deep insight into the problems of the child, and sensible advice as to therapy makes the addition of his chapter on the Psychopathological Problems of Childhood a complete and fitting close for the book.

T. M. C.

**SURGICAL PRACTICE OF THE LAHEY CLINIC:** by Members of the Staff of Lahey Clinic, Boston. 1014 pages, 784 illustrations on 509 figures. Philadelphia and London: W. B. Saunders Company, 1951. Price \$15.00.

This volume is similar to the one published in 1941 under the same title. However, it is, for all practical purposes, a new work. It is considerably amplified, and presents the many changes in surgical practice which have evolved as a result of new drugs and new methods.

In addition to illustrated descriptions of surgical procedures, concise clinical discussions are presented to cover diagnosis, preoperative preparation, postoperative care, and long-term results as determined by follow-up studies.

In addition to the general surgeons, all the surgical specialists of the clinic have contributed to the book. The Departments of Internal Medicine, Allergy and Dermatology, and Gastroenterology are also represented in the surgical discussions.

**THE NEUROSES—Diagnosis and Management of Functional Disorders and Minor Psychoses.** By Walter C. Alvarez, M.D., the Mayo Clinic. 667 pages. Price \$10.00. W. B. Saunders Company, West Washington Square, Philadelphia 5, 1951.

Anyone who has heard Doctor Alvarez speak and who has enjoyed his dynamic style of presentation will want to read his book on the neuroses. He has chosen for discussion those people who become ill due to their inadequacy to meet the disappointments, the frustrations, the obligations, the tragedies, the broken hopes, the unattained aspirations, the fears, the worries, and the hatreds in life.

Drawing from a vast experience in internal medicine in dealing with such disturbed patients, Doctor Alvarez has attempted to show the medical profession the importance of recognizing and treating the patient as a person trying to solve some problem. His methods are not those of a specific school of psychiatric teaching. Rather, he seems to be able to know at a glance that the patient suffers some psychogenic disorder. Forty-five years of experience have trained him to evaluate his patients' troubles almost "intuitively." Case after case is cited in which many routine physical examinations, laboratory procedures, and expert consultations have failed to diagnose or help cure the patient's illness because the emotional factors at the base of the trouble were not contemplated. Doctor Alvarez outlines the methods of finding out what worries the patient, what makes him afraid, why he is unhappy, even though the patient has been told previously that "there is nothing wrong with you." In this book he reveals what he actually says and does for the patient in diagnosing and giving psychotherapy.

Orthodox psychiatry probably will not completely endorse Doctor Alvarez's empirical approach to the neuroses, since he seems to rely more on his own personal experience than to any well-defined psychiatric evaluation of the individual case. It is just this manner of dealing with the neurotic patient at the level of the nonpsychiatrist which gives the book its real value. The family physician is urged to be the practical, sympathetic counselor, alert to the mental and emotional factors that influence his patients as persons. The common-sense attitude, conversational style, good humor, and unselfish motivation makes his book interesting reading.

T. M. C.



# INDIANA STATE BOARD OF HEALTH

## Division of Communicable Disease Control

### MONTHLY REPORT—NOVEMBER 1951

Disease	Nov. 1951	Oct. 1951	Sept. 1951	Nov. 1950	Nov. 1949
Brucellosis	2	5	2	5	0
Chickenpox	146	45	20	177	140
Diphtheria	17	9	6	4	38
Dysentery, virus	18	0	3	0	0
Encephalitis	1	3	5	3	2
Impetigo	1	6	4	0	0
Influenza	74	31	26	21	20
Infectious hepatitis	16	3	3	3	0
Malaria	1	0	8	0	0
Measles	95	39	24	37	92
Meningitis,					
Unclassified	7	2	5	3	5
Meningococcal	1	0	1	2	2
Staphylococcal	1	0	0	0	0
Mumps	132	80	21	90	72
Paratyphoid fever	2	0	0	1	0
Pneumonia	29	20	14	62	26
Poliomyelitis	32	63	129	105	65
Rabies in animals	20	24	24	43	36
Rheumatic fever	2	3	1	1	0
Rubella	13	3	15	2	15
Scarlet fever	104	64	30	62	118
Septic sore throat	8	4	2	0	1
Tetanus	1	0	0	1	1
Tuberculosis,					
Pulmonary	205	110	136	162	168
Other forms	24	6	5	14	18
Typhoid fever	2	3	4	2	3
Whooping cough	99	74	88	151	88
Typhus, tick borne	1	0	0	0	0

# INDIANA STATE BOARD OF HEALTH

## Division of Communicable Disease Control

### MONTHLY REPORT—DECEMBER 1951

Disease	Dec. 1951	Nov. 1951	Oct. 1951	Dec. 1950	Dec. 1949
Brucellosis	1	2	5	6	2
Chickenpox	389	146	45	341	236
Conjunctivitis	2	0	0	0	0
Diphtheria	5	17	9	7	33
Dysentery,					
Amoebic	2	0	2	1	0
Virus	1	18	0	0	0
Encephalitis	1	1	3	3	3
Erysipelas	2	0	0	2	3
Impetigo	2	1	6	2	5
Influenza	46	74	31	100	26
Infectious hepatitis	22	16	3	3	0
Measles	440	95	39	191	111
Meningitis,					
Unclassified	7	7	2	8	4
Meningococcal	1	1	0	1	8
Pneumococcal	2	0	0	0	1
Mumps	289	132	80	82	147
Pneumonia	44	29	20	74	45
Poliomyelitis	11	32	63	35	29
Rabies in animals	27*	20	24	33	39
Rheumatic fever	3	2	3	1	0
Rubella	20	13	3	13	75
Scarlet fever	182	104	64	146	200
Septic sore throat	4	8	4	1	0
Tetanus	1	1	0	0	0
Tuberculosis,					
Pulmonary	210	205	110	139	111
Other forms	6	24	6	11	8
Tularemia	3	0	0	7	7
Typhoid fever	1	2	3	2	3
Whooping cough	108	99	96	212	87
Trichinosis	2	0	0	0	2

\* Corrected total

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MARCH, 1952

NUMBER 3

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### ALLERGY OF THE EAR AND ALLERGIC DEAFNESS\*

HUGH A. KUHN, M.D.

*Hammond*

**A**LLERGY<sup>1</sup> is a word that was coined to designate an altered state of an organism so that its victims respond in a most unusual manner when it comes in contact with certain materials in amounts that otherwise are not harmful. Consequently an allergy must be distinguished from an idiosyncrasy or an intolerance. In these two, the response is the usual one but the amount of exposure (dose) that is necessary to produce the full physiological effect may be very much less than the usual one. For example, every human being will get a ringing in his ears if he is given enough quinine. This is then a normal response to quinine, as it is to streptomycin, no matter how much or how little it takes to produce it. This we may term an idiosyncrasy or intolerance. A small percentage of individuals, however, when given

quinine break out with hives. Now hives is not the usual response to quinine; something has altered the state of these persons, and so we use another word for it and call it allergy to quinine.

We recognize then that in allergy we are dealing with a condition or state of the person which may result in disease when the victim comes in contact with the substance to which he is now allergic—his allergen. Modern medicine has learned to control these allergic reactions and so do away with them through the use of avoidance, elimination, substitution, identification programs, or by overcoming the allergic condition through the use of graduated injections—hyposensitization, as it is called. In these ways allergic persons are kept comfortably relieved from their debilitating exacerbations. The medical profession knows much less about changing the allergic constitution back to normal. There is hope today that the newer drugs,

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\* Presented at the annual session of the Indiana State Medical Association, at Indianapolis, on October 31, 1951.

ACTH and cortisone, may become the tools by which this problem will be solved, but all that is for the future. At the present time they offer an opportunity for protection against the ravaging symptoms of acute episodes, but offer no lasting improvement.

Then, the allergies of the nose and ear are unusual reactions of the nose and ear tissue to an allergic stimulant which is different from the ordinary reaction that one would expect from the same or a similar stimulus. These are manifested in peculiar ways and interfere with the normal functions. The symptoms of nasal allergy are: itching, sneezing, obstruction from swelling of the mucous membrane, watery discharge, pain from the blocking of the ostium of the sinuses, and the promotion of secondary infections in the sinuses, or the development of nasal polypi if the stimulant continues. One can say that nasal polypi are always due to allergic reactions of nasal mucous membranes. If any inhalation or injection of a specific allergen causes a dullness, fullness, pain in the ears, lowered hearing, tinnitus, increase or change in the discharge in an otorrhea, allergy of the middle ear must be considered.

**DIAGNOSIS:** The history of inheritance of allergies varies in its manifestations in different members of a family, but about 10 percent of the population has allergies of one type or another. The history of the disease and its attacks and of the nose findings are of a preponderance of eosinophils in the nasal secretion. These nasal polypi that are removed from allergic noses are found on section to contain many eosinophils also, in addition to their watery mucoid structure.

**TREATMENT:** In the management of an established nasal sinusitis and polyposis it does not follow that the treatment of the allergies will always completely correct the situation. One must be certain that the proper therapy for each particular case is instituted, which consists of reducing the infection by antral lavage, general physical build-up, decongestant applications to the nose, suction for removal of excessive secretions, and careful allergic studies to determine the cause of the disturbances. The primary disturbance is usually of allergic origin and the secondary disturbance of secondary infectious origin. From the surgical standpoint, it is important that the normal anatomical status of the nose be re-established in addition to

adding the corrective medical measures of returning nasal physiology to normal. If the nose is filled with polypi, they need to be removed as an initial step in the procedure. If the antra and ethmoidal sinuses are loaded with polypi and the normal mucous membranes are non-functioning or are destroyed, it is necessary to remove them. The management of infections in allergic patients does not vary from the management of nonallergics, except that additive measures are employed. In cases of deviated septums with nasal obstruction and difficulty in breathing, great relief is obtained by a submucous resection of the nasal septum. In fact, this offers one of the greatest helps in the commonest nasal obstructions.<sup>2</sup>

#### ALLERGIC DISEASE OF THE EAR:

Allergic disease of the ear should be divided into three groups:

##### Allergies of:

1. The external auditory canal and adjacent tissues.
2. The middle ear.
3. The inner ear.

#### THE EXTERNAL EAR:

Allergic otitis externa is a dermatitis characterized by hyperemia, inflammatory reactions, edema, and in severe acute cases, vesiculation. In the more chronic types, eczematoid changes occur. Allergic dermatitis is more frequent than is generally supposed and is due to the effect of some contact irritant or allergen to which the patient is specifically hypersensitive.

Fur neckpieces or fur collar trimmings are fairly frequent causes for reaction about the ear. Cosmetics are suspect, particularly those containing orris root, i.e., face powder, face cream, lotions, et al. Intermittent exposure to an irritant may give rise to a puzzling otitis externa which varies in severity from day to day. Fingernail polish, scalp lotions, medications used about the ear, perfumes, essential oils, phenol, cresylic acid, the temple pieces of spectacles, and sulfonamides may be offenders. Treatment resolves itself into the following: elimination of the irritant responsible for the lesion, if it can be discovered, correction of deficiencies of diet and vitamin intake, and the



use of such local applications as are necessary to aid in correcting the changes which have taken place in the skin.

Care should be exercised in the choice of local applications and treatment, for the drug that is intended to clear up a local situation may, through its irritant properties, serve to perpetuate it. The diagnosis of external otitis frequently, even if of an allergic nature, is considered to be due to fungus growth. However, this does occur but relatively rarely as a primary cause; it occurs rather as a secondary invader, as do many saprophytic bacteria. The list of local applications for the correction and palliation of the itching, burning, discharge and dermatitis that follows, and which is usually secondary, is a long one in the history of medical treatments ranging from hydrogen peroxide and many combinations with it, through the sulfa drugs to zinc oxide and on through nearly forty remedies. However, very careful cleanliness and repeated treating of the entire external ear with dry applicators or with applications of pure alcohol will greatly quiet down the local manifestation and control the situation until the allergic factors can be taken into consideration and relieved by eliminating the irritant responsible for the situation if and when they are of an allergic nature. We use small doses of staphylococcus toxoid, one-tenth to one unit, and when fungi are discovered small doses of one-tenth to five-tenths of a mixture of trichophytin, epidermophytin and monilia in a dilution of one to one hundred thousand.<sup>3</sup> Also, frequent applications of silver nitrate, 2 to 20 percent, to the abraded areas is helpful. A neurodermatitis and a seborrheic dermatitis are frequently noted here. They appear much the same and can be differentiated by giving doses of cortisone. The neurodermatitis disappears in two or three days and then promptly recurs when the cortisone is stopped. The seborrheic dermatitis is best controlled by an ointment of 2 percent sulfur ointment.

#### THE MIDDLE EAR:

Allergies of the middle ear are frequently those that cause change of hearing and are frequently of the combined lesion deafness type, i.e., involving both high and low sound frequencies, but oftener in the high frequencies only, thus simulating a nerve deafness. The loss

of hearing is dependent on the location of the affected or shock tissue and the commonest symptoms are deafness, fullness, dullness, deep-seated pain, itching between the nose and ear and a burning sensation in the ear. In our experience, excluding the senile deafness cases, we find a distinct diagnosis of allergic deafness in approximately 2 percent of hearing difficulty cases. They are found for the most part in the first twenty years of life. The diagnosis is rather easily established by making first a careful audiometric recording and then giving the patient a test which consists of a hypodermic dose of adrenalin, then repeating the hearing test in fifteen to twenty minutes.<sup>4</sup> If there is an immediate change in the hearing one can deduce that there is likely an allergic factor and be on guard to determine the allergens responsible and then add this therapy to the other therapies that are indicated. We have found the commonest allergens to be inhalants and foods.

#### CATARRHAL OTITIS MEDIA:

In the deafness that comes with a secretory catarrh of the middle ear it has been noted for a long time that the secretion frequently contains eosinophils and these episodes are often accompanied by an acute nasal allergy. The relief of this type of situation is much quicker and the repetition of attack much less likely if the allergic factors involved can be sought out and avoided. A repeated catarrhal otitis causes insidious permanent hearing changes.

#### CHRONIC RECURRENT CATARRHAL OTITIS:

In a recurrent catarrhal otitis with its resultant hearing losses, careful cytology studies of the middle ear fluid is essential and often adds greatly to the efficiency of therapy. I remember seeing a young man of twenty-some years of age, who had had twenty-one myringotomies in five years for twenty-one attacks of catarrhal otitis. His drums were thin, scarred and had some calcareous deposits, giving them a ground-glass appearance. Yet he had very little loss of hearing. No smears had been made on the fluid from these myringotomies and no smears of his nasal secretions had been made, either. He was cured of these yearly recurrences by having his nasal polypi removed, dust desensitization and by avoidance of tobacco. Recently

a confrere from a distant city reported that this same patient, five years later, after a climate change, had some asthma and nasal allergies which again cleared up by proper allergic therapy without recurrence of his middle ear involvement.

#### RADIUM APPLICATION:

A very fine result in some hearing difficulties in children has been accomplished by the use of radium to the nasopharynx to cut down the hypertrophic lymphoid tissue and thereby destroying its possibility of encroachment on the eustachian tubes thus obstructing the middle ear. I believe that those cases in which a fine therapeutic result is obtained from radium are allergies, and that this matter of the use of radium has for its effect the nonspecific reaction of traumatized tissue in addition to the reduction of the lymphoid tissue. In many instances where we have obtained good results we have been able to find a high eosinophilia in the nasopharynx.

#### EOSINOPHILIC AND AEOSINOPHILIC EAR:

In chronic otorrhea, if the perforation is central, eosinophils may be frequently found in the secretions and unless the etiologic factors are discovered and removed by avoidance or hyposensitization these will remain chronic and undergo frequent episodes with changes in the secretion with every acute allergic episode and cold. They will show very slow healing if the mastoid itself is invaded and surgery becomes necessary.

The aeosinophilic ear usually has a marginal perforation and bone changes with necrosis or cholesteatoma. When carefully cleaned out these heal much quicker than the eosinophilic ears.

When middle ear tissues are sensitized locally early in life they have a developmental inhibition to good pneumatization and normal development of the middle ear mastoid air cell system and increase thereby the opportunity for chronic otitis and mastoiditis.

It has been considered by Dolman that when babies are artificially fed they lie flat on their backs, and as they have straight eustachian tubes this offers one of the best opportunities for local sensitization to cow's milk. In his series of cases 86 percent were artificially fed, and indeed the

commonest sensitivity was to cow's milk. So we see that the middle ear can be assaulted from an allergic standpoint either by foods or inhalants or by local sensitization.<sup>5</sup>

#### INNER EAR:

Allergies affecting the inner ear have the following symptoms: tinnitus aurium, vertigo, unpleasant clicking noises, and unilateral or bilateral hearing defects.

Endolymphatic hydrops is the syndrome of physical or intrinsic allergies. In a discussion of allergies of the cochlea and labyrinth, commonly referred to as Meniere's syndrome, there is a great difficulty in sharply dividing and classifying the symptoms. There may be vertigo, nausea, and vomiting, with or without hearing loss. The typical Meniere's diagnostic triad is vertigo, tinnitus, and deafness. There is much evidence to justify the classification of a Meniere's syndrome as an allergy and it frequently involves other structures of the head with accompanying myalgias and neuralgias. There are many cases of pathologic findings showing dilatation of the endolymphatic system,<sup>4</sup> degenerative changes being present in the sensory elements of the inner ear and showing no inflammatory changes. Pathologic specimens and descriptions are reported by Hallpike and Cairns in England, and John Lindsay of Chicago.

A characteristic "endolymphatic hydrops" is a noninflammatory extracellular edema fluctuating in symptoms and is quite consistent with an allergic etiology. However, it is difficult to find the pathologic picture of a fluctuating extracellular edema in the body without having an allergic background or etiology. The disease usually starts in middle life, sometimes as early as the third decade. Vertigo may be the first symptom but often it is tinnitus and a deafness that is frequently profound and quick in its onset, the loss of hearing amounting to as much as forty decibels in a few minutes. The deafness may involve only the lower frequencies, but it is usually progressive and actually involves all the frequencies for both air and bone conduction. It may affect one or both ears and it occasionally happens that there may be little or no vertigo. The tinnitus and deafness progress in a typical manner. Treatment consists of careful allergic study, elimination diet, histamine diphosphate injection and rest.



# CONCLUSIONS:

Nasal allergies are quite common in the practice of ear, nose and throat.

Allergy of the middle ear is an unusual reaction to an allergic stimulus and is characterized by changes in hearing, catarrhal otitis, and eosinophilic otorrhea.

Surgical intervention is sometimes avoided and its efficiency many times increased in both ear and nasal conditions by recognizing the allergic basis of the pathologies.

A test is given for the diagnosis of allergic deafness.

Inner ear deafness is discussed and indications of treatment suggested.

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## FIXED DRUG ERUPTIONS FROM SULFADIAZINE

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**I** OUR KNOWLEDGE there has been only one case report of a child with a fixed drug eruption from sulfonamides. The lesion was produced by sulfadiazine. This report records another instance in a child from sulfadiazine present in a mixture of sulfonamides which had been given for treatment of the common cold.

### REPORT OF A CASE

The patient was a white girl, age 3. She was examined August 10, 1951. On the right medial thigh was an ovoid lesion measuring 1.5 by 2 centimeters. The long axis followed the normal clefts in the skin and coincided with the line

of tension from the elastic in the leg of her underpants. Spreading from the central portion of the lesion were concentric bands of color varying from bright red to purple. The dermatitis appeared in November 1950 as a reddened area. In a few weeks the color faded to a light brown which persisted as a hyperpigmented patch. In March 1951 the patch became bright red again, then faded. The following August a similar event was noticed.

The drug history disclosed that at the time of onset a "cold medicine" had been given, and the same medicine had been taken prior to each subsequent recurrence. A copy of the prescrip-

tion was obtained, and the manufacturer listed the following ingredients:

Sulfadiazine  
Sulfamerazine  
Methyl-P-Hydroxybenzoate  
Tragacanth  
Citric Acid  
Sodium Citrate  
Starch  
Acacia  
Saccharin Soluble

Rather a formidable list of chemicals for the common cold.

Sulfadiazine was administered in a dose of about 0.65 grams. Within a few hours itching developed at the pigmented site, followed by the appearance of erythema in less than four hours. No other signs or symptoms were noted.

The child was born August 7, 1949. A rash in the diaper region had been present off and on, and a variety of topical remedies had been applied. When she was 8 months old a "cold" was suspected and an oral medicine was prescribed. A note to the pharmacist in a nearby state confirmed the medicine to be sulfadiazine. The mother had taken sulfonamides for sinusitis 2 years before the child was born. The father was susceptible to poison ivy.

#### DISCUSSION

In 1944 Freeman<sup>1</sup> reported the first case of a fixed drug eruption from sulfadiazine. The patient was a physician, age 35, and the fixed site was the dorsum of the right thumb. Sulfadiazine had been taken for arthritis. Six hours after ingestion of sulfadiazine the lesion recurred. An exacerbation was also produced by taking sulfamerazine. In 1946 Cole<sup>2</sup> reported three cases from sulfadiazine. A white soldier developed the fixed sites in the mouth and the shaft of the penis. Sulfadiazine produced a flare-up of the lesions within two hours. A soldier of Japanese descent had fixed sites in the mouth and glans penis. Sulfadiazine produced recurrences of symptoms in one hour. Another white soldier had mouth and penile lesions. Symptoms were produced by sulfadiazine within three hours. In 1949 Meltzer<sup>3</sup> presented the case of a white male, age 33, who developed a fixed eruption on the right thumb from sulfadiazine. Sulfonamides had been taken for sinusitis. A 10 grain dose of sulfadiazine and the same dose of sulfamerazine produced a re-

currence in two hours. Photosensitization was ruled out by covering the thumb. A second recurrence was produced by 20 grains of sulfadiazine, and in addition this dose was followed by a fixed lesion on the penis. A Prausnitz-Küstner passive transfer test produced a negative result. Sulfamerazine in a dose of 20 grains produced symptoms in 30 minutes and a recurrence of the thumb lesion in six hours. The administration of para-aminobenzoic acid in a dose of 20 grains had no effect. In 1951 Philpott<sup>4</sup> reported two proven and one suspected case. A white male, age 26, had taken sulfadiazine off and on for a period of four to five years. He developed a persistent patch of hyperpigmentation on the left anterior chest, and following the further use of sulfadiazine a lesion appeared on the penis. One gram of sulfadiazine produced an exacerbation of the lesion on the chest and penis within two hours. An oriental boy, age 5, presented a fixed lesion on the right flank. Sulfonamides had been prescribed routinely for minor illnesses. The administration of sulfadiazine produced a flare-up of the lesion. A negro woman, age 26, had been given a sulfonamide mixture for a urethral diverticulum and trigonitis. Within 24 hours old areas of pigmentation on the lips, forearms, hands and legs became pruritic and urticarial. She had received sulfonamides a year before for the same condition.

#### COMMENTS

Sulfadiazine produces "fixed lesions" involving the skin, mucous membranes, or both. Out of seven proven cases, two cases occurred in children. Repetition of an adequate dose appears to increase the number of "fixed lesions." Either sulfadiazine or sulfamerazine, or in our case, sulfathiozole, can activate a "fixed site." They differ chemically only in that sulfamerazine has a methyl group attached to the pyrimidine ring.<sup>3</sup>

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# DIFFERENTIAL DIAGNOSIS OF CIRCUMSCRIBED DISCRETE PULMONARY LESIONS

## Review of Six Cases Treated Surgically

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A SINGLE, discrete lesion in the lung is occasionally encountered as an unexpected finding, or may be brought to our attention because of symptoms directly suggestive of pulmonary disease. In either event, the problem of differential diagnosis is a difficult one in consideration of the large number of abnormal entities which may occur. In Table No. 1 are enumerated several series to illustrate the variety and distribution of solitary circumscribed tumors as found in cross sections of random groups. The series of Effler et al.<sup>1</sup> is representative of an asymptomatic group observed during a period of 18 months at Walter Reed General Hospital. All of the patients cited by Thornton et al.<sup>2</sup> were thought at some time during the course of their illness to have a neoplasm, while the 91 cases reported by Bloch et al.<sup>3</sup> typify the result of routine fluoroscopic screening of 15,000 individuals in the outpatient department of the University of Chicago Clinics. The high percentage of malignancies here is in contrast to the preponderance of tuberculous lesions among the patients from Fitzsimmon's General Hospital as recorded by Mahon and Forsee.<sup>4</sup> Effler's<sup>5</sup> group of 16 cases, all asymptomatic, were found during a roentgenological survey at the Cleveland Clinic, and 10 of the 21 patients included by O'Brien et al.<sup>6</sup> from Wayne University and Harper and Kiefer Hospitals in Detroit, had no symptoms related to the tumor. The six cases to be reported by us were patients at the Robert Long

Hospital between January and July of 1950. In this small series, all of whom were women within the age limits of 45 and 56 years, six different types of lesions were found at surgery. In the study of such cases there may still be doubt regarding the exact etiology concerned even after all the diagnostic methods at one's disposal have been exhausted. The final decision regarding adequate therapy must be guided by the evidence presented at thoracotomy.

### CASE REPORTS

CASE 1—Mrs. M. G. A., aged 48 years, was referred to the Long Hospital on April 11, 1950, because of what she described as "peculiar sensations of discomfort" in her chest recurring throughout the past month. Her physician had obtained a chest plate and found a circular density in the left upper lung field. There had been no acute distress or localized chest pain, no fever, productive cough, or recent weight loss. There was a background of chronic bronchitis and frequent colds. Her physical examination upon admission revealed no demonstrable abnormalities of the heart or lungs. There was evidence of irradiation changes in the skin over the pubis, and of perineal scarring which dated back to 1937. At that time an inflammatory lesion of the left labium was removed surgically and associated changes in the pubic bones were treated by x-ray. The possibility of a chronic tuberculous condition was suggested by a consultant, but was never positively confirmed.

Because a pulmonary metastatic lesion was suspected, this patient was checked by retro-

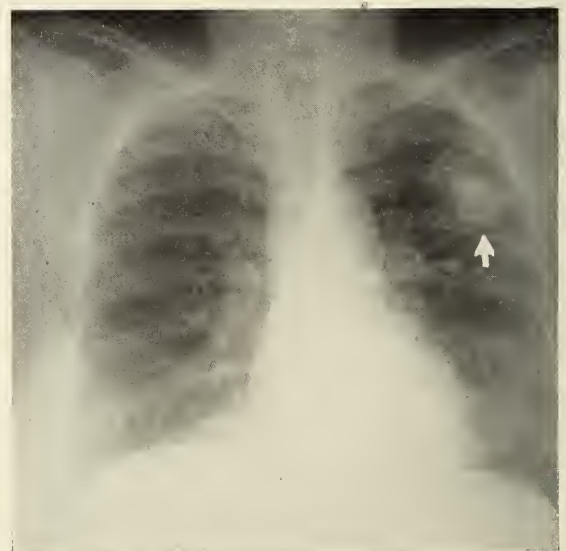
From the Departments of Medicine and Surgery, Indiana University Medical Center, Indianapolis, Indiana.

TABLE No. 1

Type of Tumor	Bloch et al.		Thornton et al.		Effler et al.		Mahan & Forsee		Hare & Battersby		Effler		O'Brien et al.	
	No. of Cases	Per- cent	No. of Cases	Per- cent	No. of Cases	Per- cent	No. of Cases	Per- cent	No. of Cases	Per- cent	No. of Cases	Per- cent	No. of Cases	Per- cent
Chronic Abscess -----			1	4.3			1	1.6	1	16.6			2	9.5
Bronchial Adenoma ----							1	1.6	1	16.6				
Bronchiectasis (calc. cast) -----							1	1.6	1	16.6				
Carcinoma														
(metastatic) -----	34	37.3	3	13.0	1	4.2	1	1.6	1	16.6	1	6.25		
(primary) -----	25	27.4	12	52.1	1	4.2	2	3.2	1	16.6	6	37.5	8	38.1
Cyst														
(bronchiogenic) ----					6	25.0	1	1.6					1	4.7
(dermoid) -----	1	1.1			1	4.2	1	1.6						
(echinococcus) -----														
Hamartoma -----					1	4.2	1	1.6			1	6.25		
Hemangioma -----	1	1.1	1	4.3	1	4.2								
Lymphoma -----	19	21.0												
Neurofibroma -----	1	1.1			1	4.2								
Sarcomata -----	5	5.4	1	4.3	2	8.3	1	1.6					1	4.7
Tuberculoma -----			4	17.4	7	29.1	48	77.4	1	16.6	8	50.0	8	38.1
Undiagnosed -----	5	5.4												
Miscellaneous (Rare occurrence) --			1	4.3	3	12.5	4	6.4					1	4.7
Total Cases -----	91		23		24		62		6		16		21	

grade pyelography, barium studies of the stomach and bowel, and films of the long bones, pubis, and spine. These examinations showed no evidence of a primary malignancy. A roentgenogram of the chest (Fig. 1) revealed the abnormal shadow although it could not be visualized by bronchoscopy. Laboratory data included an essentially normal blood count, sedimentation rate (Wintrobe) of 37 mm./hour, sputums negative for tubercle bacilli and fungi, and ureteral urine specimens negative for tubercle bacilli. A left pneumonectomy was performed on May 3, 1950. The pathological report described a well encapsulated tuberculoma about 2.5 cm. in diameter. On cut section the central amorphous tissue was surrounded by walls having a laminated appearance and a chalky consistency. In the hilar area were healed and calcifying nodules. Tubercle bacilli were found in direct smears from the lesions.

Fig. 1. (Case 1)



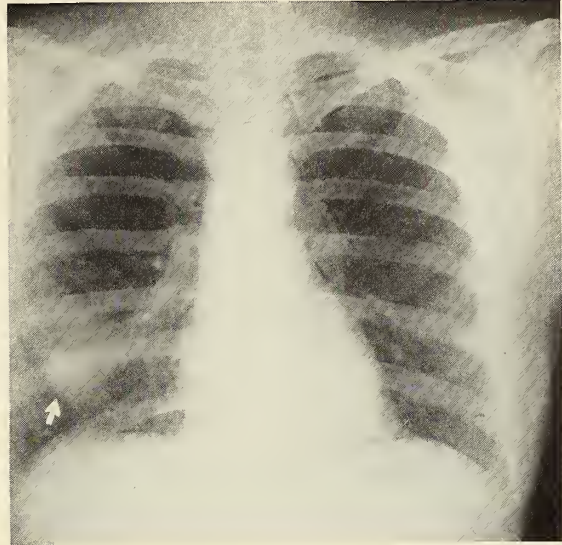
Roentgenogram showing circumscribed mass in middle portion of left upper lobe.



CASE 2—Mrs. L. C. D., aged 49 years, gave a history of having enjoyed good health until the late summer of 1949 when she began having recurrent paroxysms of coughing, brought on by lying down. These would last up to five minutes and were accompanied by dyspnea and a choking sensation initially, but recently she had coughed up a teaspoonful of blood on three occasions. A roentgenogram (Fig. 2) taken in September by her local physician showed a density on the right side and she was put to bed until first admitted to the Long Hospital the middle of October, 1949. Bronchoscopic study at this time failed to reveal the lesion but she continued to have episodes of hemoptysis and so was readmitted on February 14, 1950, for surgical exploration. Her family history was negative for tuberculosis. Her physical examination was essentially normal and laboratory data included a blood count within normal limits, sedimentation rate (Wintrobe) of 5 mm./hour, and culture from bronchoscopic secretions positive for streptococci. She was taken to surgery on February 15, 1950, with the preoperative diagnosis of carcinoma of the right lung. A firm lesion was found near the periphery in the lower lobe and a lobectomy was performed. Pathological diagnosis of the specimen was an infiltrative lesion distal to a broncholith located in an anterior tertiary branch of the right lower lobe bronchus. This comprised an area of segmental bronchiectasis with chronic interstitial pneumonia and suppurative bronchitis.

CASE 3—Mrs. M. C., a 56 year old business woman, consulted one of us (L.H.) the middle of June, 1950, because of the sudden onset, one week earlier, of fatigability, anorexia, a non-productive cough, and pain in the left hip. There were no remarkable physical findings at this time, but because of a temperature of 101.2° F., leukocytosis of 16,800 with 23 percent bands, and a sedimentation rate (Wintrobe) of 54 mm./hour, she was treated expectantly at home with penicillin for four days, followed by chloromycetin for two days. Her response was not satisfactory, so she was admitted to the Long Hospital on June 21, 1950, for diagnostic studies. Her past history revealed that at the age of 21 she had had a prolonged illness with cough and pain in the right shoulder diagnosed as pleurisy. Sputums had been checked and found negative for tubercle bacilli. An older brother had died of tuberculosis when he was

Fig. 2. (Case 2)

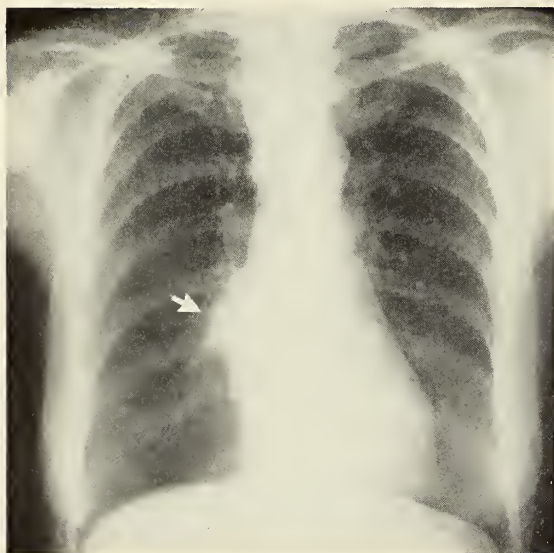


Roentgenogram taken prior to admission. The lesion is located in the right lower lobe.

15. It is of interest that she had been hospitalized in April, 1950, for surgical investigation of an apparent filling defect 4 cm. above the cecum. Examination revealed only an adhesive band in this location and careful palpation failed to demonstrate any abdominal or pelvic abnormality. A screening 35 mm. chest film taken at this time was interpreted as negative.

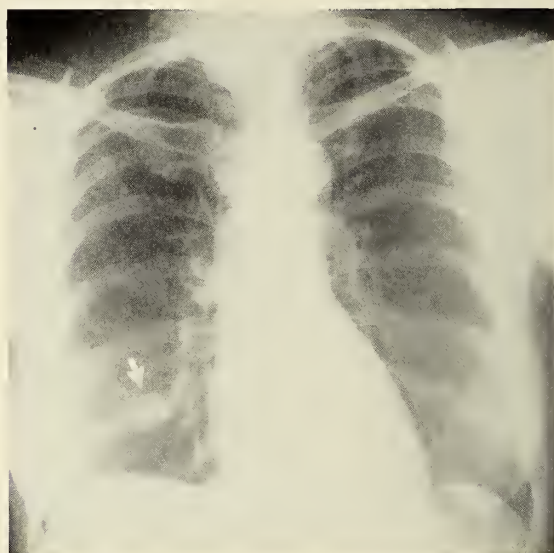
The initial roentgenogram of the chest on June 21 (Fig. 3) showed a homogeneous oval density in the right hilar area and a mulberry type calcification in the peritracheal lymph node structures. Fluoroscopy demonstrated an asymmetrical widening of the upper mediastinum and displacement of the barium filled esophagus to the left and anteriorly. Diagnostic procedures were planned to determine the likelihood of a primary or metastatic malignancy, a tuberculoma, an encapsulated abscess, or a mediastinal cyst. A tracer study with  $I^{131}$  resulted in a normal uptake over the thyroid gland which was deemed adequate to rule out a substernal extension. By planigraphic and bronchographic studies the tumor was located within the apex of the right lower lobe. A negative intravenous pyelogram, coupled with the recent abdominal exploration, ruled out the likelihood of this being a metastatic lesion. Sputum cultures were negative for tubercle bacilli, but a tuberculoma was considered when she was taken to surgery on July 5. Following adequate exposure, palpation of the upper mediastinal mass strongly suggested

Fig. 3. (Case 3)



Roentgenogram demonstrates a mass in the right hilus area.

Fig. 4. (Case 4)



Roentgenogram showing a tumor in the right middle lobe.

a lipoma and this was not disturbed. The other tumor, 4-5 cm. in diameter, was readily located and removed by performing a right lower lobectomy. The mediastinal nodes were of normal consistency.

The pathological report described this as a healed granulomatous lesion, the center of which contained a thick sterile pus. Two small satellite lesions showed central caseation necrosis. The surrounding area revealed changes compatible with bronchiectasis, purulent bronchitis, and pulmonary fibrosis. The etiological agent in this lesion has remained obscure.

CASE 4—Mrs. L. S. J., aged 45 years, had enjoyed good health until the fall of 1949. A chest roentgenogram was made in December because of a prolonged cold associated with a productive cough and increased fatigability. This showed a small spherical shadow in the right lung. There was no history of tuberculosis, but she had been a heavy cigarette smoker for many years. There were no abnormal findings on chest examination; her blood pressure was 170/100. A hemogram was within normal limits and the sedimentation rate (Wintrobe) was 4 mm./hour. This lesion remained unchanged in size on subsequent films (Fig. 4) and she was admitted to the Long Hospital on March 14, 1950. Her white blood count was then 12,850. A planigraphic study showed a solid tumor, 2 cm.

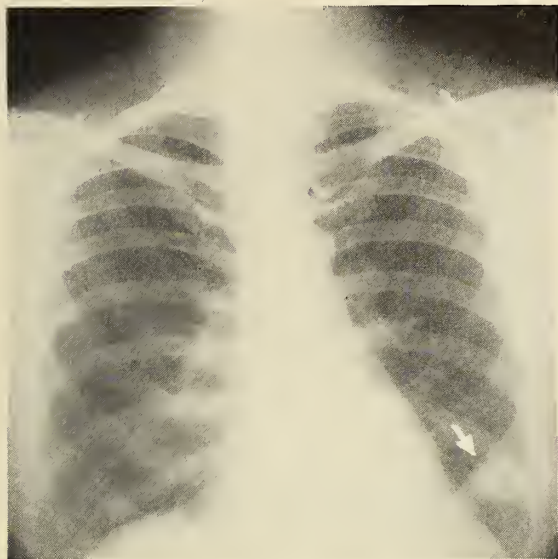
in diameter, located below the anterior chest wall in the middle lobe. A malignant lesion was suspected and confirmed by biopsy, so a right pneumonectomy was performed on March 16, 1950. The histological diagnosis was papillary adenocarcinoma. Her postoperative course was complicated on the second day by periods of cyanosis and dyspnea and death occurred on March 17, 1950, due to an embolus from the right lower extremity to the left pulmonary artery.

CASE 5—Miss M. C., aged 51 years, was admitted to the Long Hospital on January 20, 1950, for surgical removal of a suspected metastatic lesion in the left lower lobe (Fig. 5). This was a silent lesion, having been found on a routine fluoroscopic examination on January 16, 1950. Her general health had been excellent, with no complaints referable to cough, chest pain, or weight loss, since her previous surgery on June 17, 1949. At that time a portion of the sigmoid colon was resected because of a well differentiated adenocarcinoma; there was no evidence of any local metastases and an end-to-end anastomosis was accomplished.

At surgery, on January 21, exposure of the left lower lobe revealed a discrete mass as anticipated, and this lobe was removed without difficulty. The pathological report revealed a metastatic adenocarcinoma.

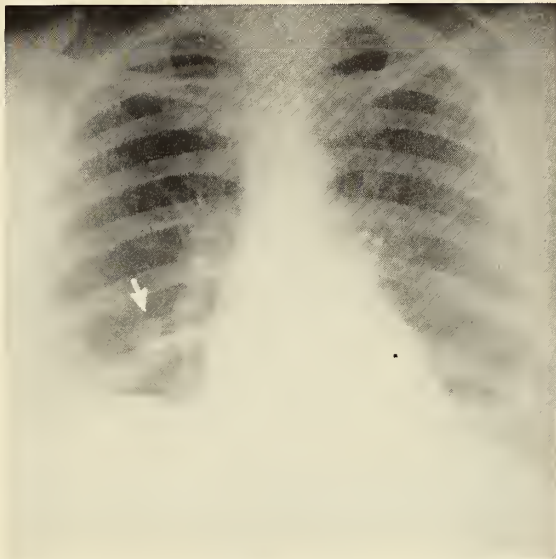


Fig. 5. (Case 5)



Roentgenogram demonstrates a discrete rounded lesion in the left lower lobe.

Fig. 6. (Case 6)



Roentgenogram taken in November, 1949, prior to admission. A tumor is located in the right middle lobe.

CASE 6—Mrs. C. H. P., an obese housewife, aged 48 years, was told she had a lesion in her right lung when a roentgenogram (Fig. 6) was made in November, 1949, as part of a routine examination. This was a chance finding as she had had no recent illness and no symptoms referable to her chest. In March, 1950, she was bronchoscoped but the lesion was not accessible so bronchial washings were obtained and a bronchogram made. The former showed no tumor cells or tubercle bacilli and the cultures were negative. The latter indicated obstruction of secondary bronchial divisions of the medial aspect of the middle lobe. She was admitted to the Long Hospital on March 31, 1950, for surgery. Physical examination at this time revealed moist rales in the right base posteriorly, but no other pertinent findings. Her leukocyte count was elevated to 16,300. A bronchial adenoma, inflammatory reaction, or bronchogenic malignancy was suspected when she was taken to surgery on April 3, 1950, for a right middle lobectomy. The pathological diagnosis was a bronchial adenoma, growing primarily in an expansile manner, one portion within the lumen of a small bronchus and the other portion compressing the pulmonary parenchyma.

#### DISCUSSION

The question may be posed as to what are the most valuable diagnostic methods upon which

to rely. This cannot be determined arbitrarily in advance, but a comprehensive plan should be outlined from which pertinent procedures are then selected, depending upon the case. Although often disappointing, a careful history should serve as an introduction to every study. In some cases no symptoms suggestive of a chest problem will be elicited as exemplified by the series reported by Effler et al.<sup>1</sup> and by Effler.<sup>5</sup> Among the cases of O'Brien et al.<sup>6</sup> 10 of the 21 were free of any symptoms related to the chest lesion, and in two of our cases a pulmonary lesion was not anticipated. Nevertheless it is helpful to learn of a previous tuberculous infection or contact, of a recent surgical episode possibly complicated by aspiration, or of surgery in the past for removal of a primary malignancy. At least in an appreciable number of cases medical care is sought because of symptoms induced by the pulmonary lesion. Those signs and symptoms most frequently encountered include cough, hemoptysis, dyspnea, chest pain, weakness, and loss of weight. Certainly the persistence of any one of these should make us doubly suspicious that we are not dealing with a transient infectious process. The resemblance of these manifestations to a pneumonia, asthma, an embolus, a cardiac problem, or even a diaphragmatic hernia, is aptly pointed out by Alexander;<sup>7</sup> when encountered, a careful search of the lung fields is definitely indicated.

Physical examination of the chest is usually negative, which means that many early, operable lesions will be missed. If a tumor mass is covered by as much as 5 cm. of air-containing lung, its presence cannot be revealed by a change in the percussion note. Likewise small areas of consolidation or cavitation, unless very close to the surface, will fail to modify the fremitus or breath sounds. It is only in the advanced, usually inoperable stage, that we are aided by demonstrable findings of atelectasis and effusion. Blood studies are of little diagnostic aid: a leukocytosis generally accompanies a fever and is suggestive of an associated infection; the sedimentation rate appears to be an unsatisfactory criterion upon which to base judgment.

We turn then to fluoroscopy and roentgenograms, both posteroanterior and lateral views, as invaluable in the initial discovery of a silent pulmonary tumor. A planigram may be desirable to localize more accurately the area under study. Selection of additional diagnostic aids will depend largely upon this localization, whether peripheral or central. If the lesion is accessible, bronchoscopy is indicated in the hope of obtaining a biopsy which could prove the identity of an adenoma or carcinoma. Even if this approach is unsuccessful, bronchial secretions or washings, thus aspirated, may be studied for tumor cells and further examined by culture and animal inoculation. A bronchogram aids in localizing an occluded bronchus in the more peripheral areas, but fails to distinguish the type of obstruction. Although Jackson et al.<sup>8</sup> found atelectasis in 19 of 20 cases of adenoma, this is not pathognomonic of that type of lesion. Madore,<sup>9</sup> in a review and analysis of 70 cases of bronchogenic carcinoma, suggests that a homogeneous area of atelectasis may be indicative of a carcinoma, an adenoma, a foreign body, or some inflammatory condition of a bronchus. Statistics are of value only in a very broad sense; the fact that a malignant pulmonary lesion occurs more often in the age group past 45 and predominantly among men, whereas adenomas are usually found in women under 40, proves nothing in a specific case.

In every individual having a productive cough careful analysis of the sputum should be made. The remarkable accuracy which may be achieved, using the Papanicolaou technique of fixation and hematoxylin and eosin staining in the identification of malignant cells, is emphasized by

Woolner and McDonald.<sup>10</sup> Their study of sputum and bronchial secretions in a group of 588 patients proved more effective than bronchoscopic examination; positive biopsy studies were obtained in 41 percent of a group of 93 definite cases of bronchogenic carcinoma, while in the same group cytologic studies were positive in 70 percent. One might have expected a higher biopsy percentage in view of the fact that Adams<sup>11</sup> states that 70 to 75 percent of bronchogenic carcinomas arise near the hilum. In distinguishing between a malignant tumor and a discrete tuberculous lesion, Bloch et al.<sup>3</sup> point out that, contrary to the generally accepted view, cavitation may occur in both instances. If sputum analyses are repeatedly negative for tubercle bacilli at the time of excavation of a lesion, a malignancy is suggested. However, this assumption can only be made with reservations, judging from the experiences of several investigators regarding the problems of postoperative dissemination in the surgical treatment of tuberculomas. From a series of 48 patients reported by Mahon and Forsee,<sup>4</sup> one is led to believe that the chances of setting off a tuberculous pleuritis or other type of centrifugal spread are relatively slight. Within their group, 16 had lobectomies, 2 had segmental resections, and 30 had wedge resections, all without complications of further activity. A tuberculoma typically possesses a fibrous capsule surrounding a caseous center, with or without calcium deposition, and is accompanied by smaller satellite nodules in about 60 percent of the cases. Regarding their etiology, it seems generally agreed<sup>4, 12, 13, 14</sup> that among adults these tuberculous lesions represent an exogenous infection rather than an endogenous reinfection. The presence or absence of viable tubercle bacilli must be determined individually. Haight and Farris<sup>15</sup> report a single case in which the lesion was sterile; Kross<sup>16</sup> cites a case, thought preoperatively to be a carcinoma, which showed numerous acid-fast bacilli on direct smear; and Maurer-Mast and Franklin<sup>17</sup> describe a large apical tuberculoma, thought to be a dermoid cyst, in which the liquified central material was sterile, but postoperatively the patient developed an empyema, the pus from which caused tuberculosis in a guinea pig.

Additional diagnostic measures should be mentioned, though their usefulness and advisability are admittedly highly controversial. According to Alexander<sup>7</sup> the value of thoracos-



copy is quite limited, aiding only in the visualization of parietal pleural implants. He also advises against the use of the needle biopsy because of the paucity of information likely to be gained, and the danger of contamination of adjacent normal tissue. After having at least narrowed the range of possible diagnoses by a systematic approach, it is agreed by all workers in this field that surgical exploration, both for diagnosis and therapy, should not be delayed. The malignant tumor is the most dangerous from the angle of procrastination, but the very fact that we are often unable to differentiate accurately among these various lesions makes each of them equally important.

Even after surgery there may still be a question regarding the specificity of certain of the granulomatous lesions. This was stressed by Graham and Singer<sup>18</sup> in their discussion of 3 cases, 2 of which showed calcification and the third bone formation in the fibrous outer capsule. The final diagnoses were still tentative, with consideration of an abscess, a congenital cyst, an interlobar empyema, or a tuberculoma. The case report cited by Mallory<sup>19</sup> likewise illustrates the difficulties encountered in reaching a decision. Pierson<sup>20</sup> lists 14 different entities which could be considered in a suspected solitary focus of tuberculosis. Weed and Woolner<sup>21</sup> studied pulmonary granulomas by bacteriologic examination of the excised foci. In addition to tubercle bacilli, other organisms encountered included *Brucella*, *Coccidioides*, *Blastomyces*, *Histoplasma*, and *Nocardia*. A negative sputum will often belie the presence of such potentially dangerous organisms. It must be concluded that a granulomatous lesion is a hazard to the patient, first because of the associated symptoms frequently encountered, as in our Case 3, and secondly because their exact diagnosis is usually obscure. This would appear to concur with the sentiment expressed by Thornton et al.<sup>2</sup> in their discussion of solitary circumscribed tumors of the lung, and of O'Brien et al.<sup>6</sup>

On the other hand, some differences of opinion exist regarding the management of a metastatic pulmonary lesion. If the primary site of malignancy has been removed or adequately controlled and the pulmonary tumor is the only manifestation of metastasis, lobectomy or pneumonectomy would seem to be warranted. Effler and Blades<sup>22</sup> describe 3 cases in whom lobectomies

were performed with satisfactory results in 2 of them at the time of writing. The patient described by Barney,<sup>23</sup> who was clinically well 13 years after discovery, and 12 years after removal, of a metastatic nodule secondary to a renal adenocarcinoma, is admittedly a unique and exceptional case. Deming and Lindskog<sup>24</sup> report an individual with a pulmonary lesion secondary to an infiltrating papillary carcinoma of the bladder in whom a pneumonectomy was performed. In spite of subsequent osseous metastases within the following year, they maintained that "the justification of eradication of a solitary distant metastatic lesion is supported on the basis of relief of symptoms and prolongation of life."

And finally, what constitutes adequate therapy for a bronchial adenoma has become a controversial question. The assumption that fulguration of this lesion through the bronchoscope is curative, must be revised, as cases are being recognized in which evidence of subsequent malignant change is unmistakable. A critical review by Graham and Womack<sup>25</sup> describes the histopathology of these "mixed tumors" of the bronchus and cases are cited which show conclusively that the original adenoma had later taken on malignant characteristics. Adams et al.<sup>26</sup> and Doty<sup>27</sup> likewise stress the danger of considering these as benign lesions and advocate their removal by lobectomy or pneumonectomy. Early radical surgery would therefore seem to offer the patient the best chance of a permanent cure.

#### SUMMARY

A brief discussion of the differential diagnosis of certain circumscribed lung tumors is accompanied by 6 case studies. Each of these patients was operated upon by one of us (J. S. B.) so that the lesions were available for histopathological study. The final diagnoses in this group, all women between the ages of 45 and 56, include a tuberculoma, a granuloma (etiology obscure), an infiltrative lesion occurring distal to an obstructing broncholith, a bronchial adenoma, a papillary adenocarcinoma, and a metastatic adenocarcinoma. With the exception of Case 4, the others in the group made good postoperative recoveries. At the time of writing all of the patients have remained free of symptoms. Adequate surgical removal of these dis-

crete tumors without a prolonged interval of expectant observation, would appear to be the treatment of choice.

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# OCULAR THERAPEUTICS\*

## Some Recent Advances of General Interest

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THE purpose of this paper is to summarize some of the contemporary trends in nonsurgical ophthalmic therapy in which the nonophthalmologist and the ophthalmologist may have common interests.

### ACTH AND CORTISONE

Because of the peculiarly common tendency of many eye diseases to be inflammatory and exudative, apparently without frank direct infection or invasion of the ocular tissues in many instances, it is not surprising that ACTH and cortisone, which inhibit these responses, have found a wide field of application in ophthalmology.

Comparing ACTH and cortisone with each other, it is generally agreed that the ocular responses are not greatly different. One important difference, however, lies in the fact that cortisone is effective locally; whereas, of course, ACTH is not.

Many eye diseases are harmful to vision as a result of pathologic processes which would be less serious or even trivial in other locations; moreover, these pathologic processes are frequently self-limited. It is against the inflammatory and exudative components of such ocular diseases that the actions of ACTH and cortisone are directed, in order to conserve as much visual function as possible, while waiting for the termination of the course of the process from either natural or therapeutic influences.

Conditions in which ACTH and cortisone have given the most favorable results are:<sup>1</sup>

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allergic or contact blepharitis, conjunctivitis, and keratitis, including some cases of vernal conjunctivitis; also, scleritis and episcleritis, interstitial keratitis, phlyctenular keratitis, non-granulomatous uveitis, and some cases of sympathetic ophthalmia. Most of these entities are amenable to cortisone therapy by topical administration, and this is the method of choice in all except the diseases of the posterior segment of the eye, for which adequate tissue levels can be obtained consistently only through systemic administration of cortisone or ACTH.

In the following conditions the results of ACTH and cortisone therapy have been variable or inconclusive:<sup>1</sup> retrolental fibroplasia, malignant exophthalmos, hemorrhagic or exudative retinitis, some cases of luetic interstitial keratitis, optic neuritis, and ocular sarcoid.

It is agreed by most observers that ACTH and cortisone are of no value in primary glaucoma, cataract, corneal dystrophies, degenerative diseases of the optic nerve, choroid, and retina, including retinitis pigmentosa and macular degenerations.

Woods<sup>1</sup> cautioned against the use of these hormones in ocular tuberculosis and in all granulomatous uveitis of unknown etiology, possibly tuberculous, since ACTH and cortisone, while appearing to have a beneficial effect by suppressing inflammatory and exudative responses, probably also inhibit the fibrosis which otherwise results in clinical healing and encapsulation of the tubercle bacillus. These substances are likewise contraindicated in the presence of pyogenic infection and in virus invasion of the cornea, particularly herpes, early in the disease.

If systemic administration is contemplated, the usual precautions and contraindications, such

as diabetes, cardiovascular disease, and mental and fluid and electrolyte disturbances, must be observed.

Dosages<sup>1</sup> with ACTH, given parenterally to adults for the treatment of eye diseases, range from 100 to 200 mg. daily in divided doses during the first few days, the exact time depending on a satisfactory clinical eosinopenic response, after which the dosage is reduced daily by about 20 mg. to a maintenance dose of approximately 25 mg. per day for several days to a few weeks. Woods<sup>2</sup> reported rapidly favorable results in three cases of ocular sarcoid following the intravenous administration of ACTH in continuous glucose-saline drip.

The usual dosage of cortisone for ocular diseases in adults is of the order of 300, 200, and 100 mg. daily, respectively, on the first three days, in divided doses, then 100 mg. daily for about one week; after this, the dose is reduced over a period of a few days to a maintenance dose of 25 to 50 mg. daily for several days to a few weeks.

Topical cortisone acetate is used in aqueous suspensions containing 5 to 15 mg. per cc. for instillation sometimes as often as every hour. Ointments contain 5 to 25 mg. cortisone per gram of ointment vehicle; they have the advantage of being used less often, usually about every three hours at maximum frequency. Sometimes it is advisable to use the aqueous suspension during the waking hours and the ointment, with its better staying quality, at night.

#### ANTIBIOTICS

Although these substances have wide application in ophthalmology and are used both systemically and locally, it is in the treatment of the large variety of external ocular diseases that antibiotics are most often employed. The newer, broad-spectrum antibiotics—aureomycin, bacitracin, neomycin, and terramycin—offer a wide choice of therapeutic agents, particularly valuable because of their effectiveness when applied locally to the eye (Table 1).

The formation of penicillinase and of penicillin resistance by certain bacterial strains, plus the frequent, hypersensitive reactions to penicillin (also true of streptomycin, especially, and aureomycin occasionally) have resulted in the limited and cautious employment of this agent

locally in the eye, it being reserved for unusually severe or unyielding infections such as palpebral or orbital cellulitis, hyperacute conjunctivitis, severe corneal ulcers, and pyogenic intraocular infection. Particularly in the two last conditions—corneal ulcers and intraocular infections—other antibiotics, as well as penicillin, given subconjunctivally, are frequently effective in the treatment of these conditions. In desperate situations intraocular use is both justified and indicated.

Chloramphenicol passes freely across the blood-aqueous barrier, into the aqueous and vitreous, after oral administration; this is not true of the other antibiotics. It also enters the aqueous readily through the intact cornea after local instillation.<sup>3</sup>

*Pseudomonas aeruginosa* invasion of the cornea or intraocular structures, usually a highly destructive process and often without effective treatment, can sometimes be adequately controlled with polymyxin, probably the antibiotic of choice, or streptomycin, although favorable results with chloramphenicol or aureomycin are obtained in some cases.

Herpes of the cornea and epidemic keratoconjunctivitis can frequently be controlled with local aureomycin, perhaps also with chloramphenicol or terramycin, although the response of these diseases is variable.

In other, commoner types of external ocular infection the choice of an antibiotic is probably most wisely made on a modified empirical basis rather than on theoretical considerations of *in vitro* experiments or tests. Although smears, cultures, and sensitivity tests should be done when possible, the need for starting treatment immediately often necessitates the almost arbitrary selection of antibiotic therapy, the subsequent response to which is an important guide to the continuing treatment, since it is well recognized that the laboratory may fail to predict the clinical response of organisms in the patient receiving antibiotics.

Examples of synergism and antagonism of certain combinations of antibiotics have been found experimentally, and, although complete clinical translations of these findings have not been made, they should be kept in mind; for example, there is a reduced antibiotic effect of penicillin in the presence of aureomycin, chloramphenicol, and terramycin;<sup>3</sup> whereas, strep-



TABLE 1  
Antibiotics For Local Ophthalmic Use  
(after Leopold<sup>3</sup>)

ANTIBIOTIC	For Instillation		For Local Injection		INDICATIONS
	Ointment	Solution	Subconjunctival	Intraocular	
AUREOMYCIN -----	5 mg/gm	5 mg/cc	2.5 mg/½cc	50T/0.1cc	Gram-positive cocci; Neisseriae; some viruses and Rickettsiae; and many gram-negative rods, including some strains pseudomonas.
BACITRACIN -----	500-1,000 units/gm	500-1,000 units/cc		10-100 units/0.1cc	Gram-positive cocci; Neisseriae; and some gram-negative rods.
CHLORAMPHENICOL --	2.5 mg/gm	2.5 mg/cc	25 mg/½cc propylene glycol	250T/0.1cc	Neisseriae; some viruses and Rickettsiae; and gram-negative rods, including some strains of pseudomonas.
NEOMYCIN -----	5 mg/gm	5 mg/cc	1.2 mg/½cc	250T/0.1cc	Gram-positive cocci and gram-negative rods, especially proteus.
PENICILLIN -----	1,000-50,000 units/gm	1,000-20,000 units/cc	50,000-100,000 units/¼cc 2% procaine	1,000-5,000 units/cc	Gram-positive cocci and Neisseriae.
POLYMYXIN -----	5 mg/gm	5 mg/cc	2.5 mg/½cc		Gram-negative rods, especially some strains of pseudomonas.
STREPTOMYCIN -----	5 mg/gm	5 mg/cc	10,000-20,000 T/½cc	1,000T/0.1cc	Tubercle bacilli and many gram-negative rods, including some strains of pseudomonas.
TERRAMYCIN -----	5 mg/gm	5 mg/cc	2.5 mg/½cc	250T/0.1cc	Gram-positive cocci; Neisseriae; gram-negative rods; and some viruses and Rickettsiae.

tomyacin and bacitracin are synergistic with penicillin.<sup>4</sup>

#### ANTIHISTAMINE SUBSTANCES

The antihistamine drugs are useful in providing varying degrees of symptomatic relief in several ocular conditions, particularly those, like allergic blepharitis and conjunctivitis and palpebral urticaria, in which hypersensitivity is an obvious component of the disease, but the antihistamane drugs are useful also in some conditions, like phlyctenular keratitis, scleritis, vernal

conjunctivitis, and perhaps even nongranulomatous uveitis, in which the pathogenesis is less well understood in terms of hypersensitive factors. Recurrent corneal erosions may also respond favorably.<sup>5</sup> Atkinson<sup>6</sup> has summarized the reports of nearly 400 clinical cases in which antihistaminic agents were administered both locally and systemically for a variety of ocular conditions, many of which had a frankly hypersensitive nature. Over half of these cases were reported to have responded favorably in obtaining relief of symptoms.

The local, ophthalmic effects of these drugs are attributable to their multiple qualities: competitive for histamine or H substance, mildly cycloplegic, mydriatic, and anesthetic. Also they may reduce the permeability of the blood-aqueous barrier.

Antihistaminic drugs used in ophthalmology are divided into four principal chemical groups,<sup>7</sup> and in clinical application each of these may vary slightly from the others in efficacy and side actions, so that a certain amount of therapeutic experimentation is justified when the clinical response is not satisfactory. The following are familiar representative examples of each of the four basic chemical types of antihistaminics used in ocular therapy: tripeleennamine hydrochloride (Pyribenzamine®), diphenhydramine hydrochloride (Benadryl®), prophenpyridamine (Trimeton®), and antazoline hydrochloride (Antistine®).

The local route of administration of these drugs is preferred in the eye, except in ocular manifestations of an associated or general hypersensitivity. Local penetration into the eye is superior to penetration following oral or intravenous administration.

#### BETA IRRADIATION

Beta irradiation of the eye is a well established form of therapy which has been used over a period of years and has a considerable amount of clinical experience and experimental evidence to insure its proper place in the treatment of certain eye conditions. It is both safe and effective when used properly, and, in some instances, has no therapeutic equivalent. Important recent advances have been made in methods of applying this form of radiation therapy.

Beta radiation consists of streams of electrons which are only superficially penetrating. Since these beta particles are absorbed very rapidly after striking the surface of the eye, the amount of beta radiation reaching the lens or other vulnerable portions of the eye is negligible in dosages ordinarily employed. There are, however, several sources from which beta radiation may be obtained, and some of these, like radium and radon, emit also highly penetrating gamma rays which certainly reach the lens and other parts of the globe, but do so in such small quantities that the tolerance dose of the lens and other vital ocular structures is not nearly ex-

ceeded in ordinary doses used for beta effect. There is more radiation hazard to the operator than to the patient, because the patient receives carefully calculated and measured doses; whereas, the operator is subjected to cumulative amounts of exposure.

At present, the important sources of beta radiation utilized in ophthalmic applicators are: radium, radium D, strontium-90, and radon. Each of these source materials and each of the applicators have their own advantages and inherent faults; these have been compared.<sup>8</sup> The choice of such an applicator depends on the operator's needs; and since these needs vary, it is probably not possible to designate one applicator as "best," although it can be pointed out that unfiltered radon is the most efficient and easiest to use.

Clinical conditions which indicate the use of beta irradiation of the eye include limbal and palpebral types of vernal conjunctivitis, small benign and malignant neoplasms about the eyes and lids, and vascularizing lesions of the cornea resulting from various causes. Among the latter group, it is to be emphasized that some patients who are subjectively uncomfortable from the irritation, lacrimation and photophobia resulting from a vascularized cornea can be helped by beta irradiation, even though the prognosis for improving visual acuity may be poor. Such patients often improve remarkably in subjective comfort following the elimination of blood vessels which have invaded the cornea. To eliminate the vessels in corneas having a more hopeful visual prognosis, of course, is an obvious indication. Except for radon applicators, which can be calibrated in terms of their gamma radiation, biologic standardization is necessary for the accurate prediction of clinical effect of each of the other applicators, since there are always minor variations in construction, loading, and output. Calibration on skin is less reliable than the rabbit-cornea method of biostandardization.<sup>9</sup>

#### FATTY ACIDS

Following the demonstration of the fungistatic and fungicidal effect of some of the lower fatty acids, Theodore<sup>10</sup> was able to show a bacteriostatic effect, *in vitro*, using a 5 percent solution of sodium propionate buffered to pH 7.3, against the common pathogens of the external eye. Because of the nonirritating, nontoxic, and



nonallergenic qualities of this preparation it has had extensive clinical trial.

Its local use by instillation into the eye was found to be effective in controlling many of the common, external ocular infections. In the more acute, or severe, conditions this preparation is generally less effective, however, than the antibiotics or sulfonamides of choice but is most useful in cases requiring prolonged treatment, particularly chronic blepharoconjunctivitis. In this condition an initial, short, intensive treatment with an antibiotic or sulfonamide is followed by several weeks of sodium propionate (Propion®) medication, a combination which represents a valuable therapeutic advance in this disagreeable and stubborn condition.

#### HYALURONIDASE

The local action of this enzyme is to cause the hydrolytic depolymerization of hyaluronic acid, one of the important ingredients of intercellular cement substance, thus reducing the normal tissue barriers to the migration of interstitial fluids.

Added to procaine solution, therefore, hyaluronidase increases the effect of this agent for local anesthesia and akinesia, or for retrobulbar use. It has also been used with some success in acute glaucoma, hypopyon, massive postoperative chemosis, and with subconjunctival injections of mydriatics, for posterior synechia.<sup>11</sup>

The amount of hyaluronidase added to solutions for subconjunctival or retrobulbar injection is usually of the order of 5 to 10 turbidity-reducing units per cc. of solution, although concentrations many times greater than this have been used in selected cases.<sup>11</sup>

#### METHYL CELLULOSE

Disturbances in the physical and chemical properties of the precorneal film are common. Arising from altered or reduced lacrimal and conjunctival secretions, these disturbances result in inadequate lubrication of the corneal epithelium with the subsequent development of ocular symptoms varying from mild irritation to severe keratitis sicca and visual loss. In some patients these findings are associated with dryness of the mouth and arthropathy.

A deficiency of tears creates an obvious need for replacement therapy, for which in the past

many substitute solutions have been used. These substances have not been completely satisfactory because of instability, high refractive index, poor tolerance, and bacterial contamination.

Recently Swan<sup>12</sup> has advocated a 1 percent aqueous solution of methyl cellulose to be used as artificial tears. This solution overcomes the disadvantages of previously used ones and is by far the best substitute therapy of this type yet devised.

Methyl cellulose<sup>12</sup> is a clear liquid, which is odorless, tasteless, neutral, and almost inert. Its lubricating and emollient properties are derived from its viscosity. For this reason, methyl cellulose may be added to other ophthalmic solutions; or drugs may be dispensed in a 1 percent methyl cellulose solution, to increase the staying quality and reduce the irritant effects of eye medications. Used in these preparations or simply as artificial tears, methyl cellulose may be instilled freely in the eye over long periods without ill effects.

#### PYROGENS

Foreign-protein therapy in ophthalmology, as well as in other fields of medicine, is not new, but some of the concepts concerning this form of treatment must be revised in accord with recent advancements in the understanding of this and related problems.

Many substances have been used and advocated in the foreign-protein therapy of eye diseases, typhoid vaccine being the most widely employed. All of these substances which produce a febrile response do so because of their bacterial content and the resulting formation of pyrogens. Pyrogens are bacterially-produced, complex, heat-stable polysaccharides which can be separated from the mother substance and which are now commercially available in a more nearly purified and concentrated form, (Pyromen®).

There is considerable evidence that significant adrenocortical stimulation results from the parenteral administration of these agents and that cortisone is therefore responsible for some of the beneficial response to this type of therapy. This has been pointed out by Newell<sup>13</sup> who stated that if this were the only effect of these products, there would be little justification for the continued use of foreign-proteins, since direct hormone therapy would be more accurate and efficient. However, since the adrenocortical

stimulation produced by pyrogens is not followed by an exhaustive phase, and presumably other body defenses are mobilized, although the exact humoral and cellular processes are poorly understood but are empirically beneficial, the continued use of foreign-protein therapy seems justified.

In addition to the usual contraindications in the aged or debilitated, pyrogen-induced fever may be dangerous also to patients who have depressed adrenocortical function from any cause, including those who have recently received cortisone therapy. When it can be given safely, it is most useful in deeply seated, agnogenic, corneal, intraocular, and optic nerve inflammations.

#### SULFONAMIDES

Applied locally in the eye, the sulfonamides are effective against a wide variety of ocular infections, including ordinary pyogenic blepharitis and conjunctivitis, corneal ulcers, trachoma, inclusion blenorrhea, and sometimes in pseudomonas infection.

Although 5 percent sulfathiazole and 5 percent sulfadiazine ophthalmic ointments are useful and still widely employed, there is a tendency, whenever local sulfonamide therapy to the eye is required, to use sodium sulfacetamide (Sulamyd®), either in the 10 percent ointment or in the 30 percent solution, sometimes in combination. The principal reasons for this popularity are: broad antibacterial spectrum and relatively nontoxic, nonallergenic nature. There are two new sulfonamide agents of similar action which are useful alternatives: 4-aminomethylbenzene sulfonamide hydrochloride (Sulfamylon®) and

3, 4 dimethyl sulfanilamidiosoxazole (Gantrisin®).

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# THE JOURNAL

OF THE

## INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

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## THE JOURNAL OF THE STUDENT AMERICAN MEDICAL ASSOCIATION

The newly organized Student A.M.A., which now includes chapters in more than half of the U. S. medical schools and boasts 15,000 members, is publishing its own journal. Volume I, Number 1, appeared in January, and promises to be a splendid publication.

Its primary group of readers will be the 26,000 medical students and 7,000 interns of the United States. It will present scientific articles, as well as dissertations of a socio-economic nature, and presentations on medical history. Its contents will be especially designed for the student and intern, and it will serve as the official publication of the Student A.M.A.

In these days of an excess of medical journals, each new journal should have adequate reason for its appearance. Since the Student A.M.A.

Journal is covering a field which has never been covered before there can be no doubt as to its need.

Two of the three scientific articles in the initial issue were written by students. They are both well written and present authoritative information on well chosen subject matter. Other features, such as the Newsletter, Washington News, instructions on the art of writing, Editorials and Book Reviews will be written especially for students and interns.

The new journal appears in a very attractive format. It will be published nine times a year, from September to June, and will be received without charge by all American medical students and interns. Subscription rate to others in the United States is \$3.50 per year.

## HOSPITAL COSTS

**T**HE COST of hospitalization (index 235.3) has risen faster since 1940 than has the general cost of living (index 171.9). Other components of total medical care have not risen nearly as fast, so the total cost of medical care, including drugs, physicians' fees and hospitalization, has risen only to 147.9, and is well below the cost of living index.

Since hospitalization is an important part of the cost of illness, it is well to understand the reasons for its expensiveness. One of the reasons is that hospitals are peculiarly exposed to inflationary pressures.

If the hospital is heated with coal, there is no alternative but to pay the price when the price of coal goes up. The same reasoning applies to food and linens, in fact to anything that is needed in the care of patients. Hospitals largely limit their purchases to necessities; if the price of an absolute necessity rises the cost of hospitalization must rise also. It is interesting to note that the prices of fuel, furniture and cotton goods have risen as fast or faster, and the price of food almost as fast as the cost of hospitalization.

The biggest single item in hospital costs is wages and salaries. It is reasonable to assume that in a time when average factory workers' wages are increasing up to an index of 265, that a hospital's payroll will increase also. Modern hospitals have at least one full time employee for each patient. Each bed in the hospital, therefore, must produce enough revenue to pay the average wage of one employee.

In a recent issue of a national magazine an interview with labor leaders was reported. One labor leader complained that the cost of hospitalization was much too high. When he was informed that 66 percent of the hospital cost was wages, and when he was asked whether he thought that hospitals should pay lower wages, his answer was that the hospital wage scales should be raised and he implied that at the same time the hospital room rates should be reduced. This, of course, is an irrational conclusion, and one which should be reconciled in some manner with those people who apparently believe in high wages when they are receiving them, but believe in low wages when they are paying a hospital bill.

Another factor in hospital costs consists of the expensive new drugs and techniques. While they are expensive in dollars they are highly efficient and their use probably is extremely economical in the long run. Patients today go to the hospital sooner, stay for a shorter time, convalesce more rapidly and get back to work much sooner than they did ten years ago.

Even with the hospital costs so high, sick people probably are getting a bargain in comparison with 1940. Lowered mortality rates and early return to productive work are two advantages which cannot be posted on the credit side of the hospital ledger.

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## MEDICAL CARE FOR MILITARY DEPENDENTS

**T**HE House of Delegates of the A.M.A. at the interim session in December, 1951, considered the problem of medical care for dependents of members of the armed forces.

A resolution introduced by the Michigan delegation proposed that, if it was determined in the future that such medical care be provided on a service basis, the medical profession should provide medical care through Blue Shield and other medical society sponsored plans.

The House Reference Committee on Insurance and Medical Service reported the resolution after thorough deliberation and recommended favorable action by the delegates. Approval was voted by the House of Delegates.

The resolution stated: "That, if in the independent judgment of the Department of Defense or Congress, the welfare of our preparedness program requires that dependents of members of our armed forces receive medical care on a service basis, then the medical profession stands ready to provide such service through Blue Shield and other medical society sponsored plans."

It was pointed out that physicians had been able to provide medical care on a service basis through medically sponsored prepayment plans, and that since many citizens who when entering the armed forces already carried voluntary insurance for this purpose, a continuation of this plan would insure high quality care and a free choice of physician.



## RHODE ISLAND AND THE JENNER AMENDMENT

**T**HE REVENUE ACT of 1951 as adopted by the Congress late in October concerned most persons because of the increased taxation it featured for everyone. But there is an amendment to this act, originally offered by Senator Jenner of Indiana, which promises to cause much discussion and debate throughout the States in the next twelve-month period.

To understand the full implications of this amendment a brief history of its origin is necessary.

The General Assembly of Indiana has a law which permits public access to the records of disbursements of public welfare funds, but which contains, among other things, a prohibition upon the use of any lists or names so obtained for commercial or political purposes of any nature.

The Federal Security Agency denied to the State of Indiana some \$20 million dollars, which it would receive annually, of Federal matching funds for social security program on the basis that the Indiana anti-secrecy law violates a Federal requirement restricting the disclosure of information concerning welfare recipients.

Senator Jenner took the problem to the Congress where he was supported in what has been termed by many as a States' victory over Federal bureaucracy. But the outburst of oratory that has started and will be continued through the coming election year will undoubtedly confuse the issue far beyond the comprehension of the average citizen.

We have already read statements emanating from politicians listing the idea of publishing, or otherwise making known the names of recipients of public assistance as "abhorrent," as a "curse" originating in Indiana, as an effort to "intimidate and debase every old-age pensioner, dependent widow, etc." and to label and "victimize them as objects of scorn by snoopers."

We will read and hear of many more such ridiculous statements in the months ahead. But what are the basic issues that transcend in importance any arguments pro or con concerning the opening of welfare records?

The real issue, beyond any doubt, is that of States Rights versus Federal control over locally administered governmental programs. For years

we in the States have been relinquishing power and controls to the Federal government, and in exchange for so-called Federal funds we have submitted to any and all bureaucratic regulations.

Must the States forever look to the Federal government for the financial solution of local welfare programs? The public assistance feature of the social security program was adopted by the Federal government in 1935 as a stop-gap measure to the old age and survivors insurance program. Public assistance on a needs basis was expected to disappear from the Federal scene, with public relief programs existing only at the State or local levels.

But what has happened? Current Federal commitments based on policies of the Federal Security Agency indicate an indefinite postponement of the disappearance of Federal public assistance plans, and meanwhile public welfare and relief programs in the various States continue to skyrocket in a time of high employment and high wages.

What about Rhode Island and the Jenner amendment?

Already we have noted agitation for legislation to bar any release of disclosure of information regarding welfare recipients. We concur wholeheartedly that such information should never be utilized for commercial or political purposes and penalties should be imposed to prevent any such abuse. But what is wrong with allowing public access to the records of disbursements of public welfare funds?

In the tenth annual report of the Rhode Island department of social welfare, issued in 1945, the public assistance was defined as a matter of "RIGHT" quite apart from "NEED." The report enumerates that under the Federal Social Security Act this basic principle, "RIGHT" to assistance, was established, and the "Public Assistance Law of Rhode Island likewise recognizes assistance to those in need as a matter of "RIGHT." The Law specifically abolishes the use of the term "pauper" and on the positive side reads:

"Section 1. It is the purpose of this act to provide that access to public assistance shall be available to any person in Rhode Island who is in need.

"Section 2. Eligibility for Public Assistance. Public assistance shall be provided un-







## President's Page



"Lives of great men all remind us  
We can make our lives sublime,  
And, departing, leave behind us  
Footprints on the sands of time."  
—Longfellow

ALL too infrequently we are afforded the opportunity to pay tribute to one who has achieved greatness through his own efforts while he is yet with us.

After more than fifty years of activity in the practice of psychiatry, Dr. Max A. Bahr has asked to be relieved of his duties as superintendent of Central State Hospital.

Upon the change in state administration a number of years ago, when the political neophytes, with reckless abandon, attempted to place in power only those who had ridden on the band wagon, with no regard for their fitness or ability, it was our pleasure to insist that mental health should not be placed on the political gridiron and Dr. Max A. Bahr should be retained in the all-important position of superintendent of Central State Hospital.

During World War I Doctor Bahr and his associate, Dr. Walter Bruetsch, gained international recognition for their stand on the malarial treatment of syphilis. This, with other contributions to psychiatric diagnosis and treatment, has placed our fellow member among the world's most recognized psychiatrists.

We all might get a lesson from the tireless efforts of our friend, Doctor Bahr. As superintendent of the largest state mental hospital, which houses over twenty-four hundred patients and has about three hundred fifty employees, his responsibilities were many. Yet it was a common occurrence to find him, at ten, eleven or twelve o'clock at night, visiting patients, calling them by their first names, in an attempt to restore them to a normal life and not be a burden on society and the taxpayers. Though he was on a salary the clock did not designate his quitting time. His interest was in the amount of benefit he could be to his patients. This in itself is greatness and one way in which we all might be great.

It was a great deal of satisfaction to Doctor Bahr to know that after a life of helpful activity, upon the occasion of the public testimonial for him on January 10, 1952, a great many tributes were from former patients.

Doctor Bahr may not be physically able to attend the International Conference on Psychiatry in June which will be held in Rome and to which he has been invited.

It has indeed been a distinct pleasure to count Doctor Bahr as one of my friends and a great honor to the Indiana State Medical Association to claim him as a member.

We deem it a privilege to wish Dr. Max A. Bahr a most restful and happy vacation.

*William Wright*

# Medical Panorama *by the* ASSOCIATE EDITOR

## FROM TENNESSEE

*The Texas State Journal of Medicine* for November, 1951, contains an article entitled "The General Practitioner on the Medical School Faculty" by the gentleman whose name appears below. Since this idea is intriguing to us, we thought our readers would be equally interested in the following excerpts.

An active visiting staff of general practitioners has been brought into the medical center at the University of Tennessee for the first time in many years. The purpose is to teach the art of general practice to the medical student.

Such a staff poses immediately the problem of where in the medical curriculum such instruction should be placed and what objective should be sought. It is hardly conceivable that the general practitioner could teach more about the scientific part of any specialty than the specialty clinics. Equally, it would be inappropriate to instruct the student in the practice of general medicine until he had accumulated a good basic knowledge. Reasoning from these two premises, it would seem that only students in their final year of medical school should be candidates for general practice training. Thus, our program allows only students in their final quarter before graduation to enter the general practice clinics.

The staff of these clinics is made up entirely of general practitioners from the area, both from the city and from surrounding rural practices.

\* \* \*

In determining the limits of general practice instruction the following goals have been tabulated:

1. To teach coordination of the knowledge obtained in the specialty clinics.
2. To teach the art of medicine.

3. To define the capabilities and limitations of the good general practitioner.

4. To give students actual experience in the practice of medicine.

Nowhere in the average medical school curriculum has there been a clinic in which the general run of patients are seen without previous selection. The student has been allowed to form an opinion on only one aspect of any medical problem. In the general practice of medicine the physician must consider the patient as an entity, not the disease as an entity. General practitioners, who every day must consider the whole patient, are the logical choice to supervise students while they learn this aspect of medicine.

The art of medicine has come in for much discussion but little concrete teaching. More "human problems" are brought to the family physician than to any other practitioner, and he should be the outstanding teacher of such arts. However, the indefiniteness of this art of medicine makes it impossible at present to organize a definitive teaching program. Our work is experimental, but it is hoped that students will gain some insight from their association.

\* \* \*

American medical students unquestionably get the finest scientific education in the world, but it is amazing how little they know about the actualities of general practice. It is hoped that association with active general practitioners will do much to further their knowledge and to persuade more young men to enter this field. Furthermore, the staff of general practitioners will have ample opportunity to demonstrate that high grade medical care is within the range of the well educated and experienced general physician.

PAUL WILLIAMSON, M.D., Director,  
General Practice Clinics,  
University of Tennessee,  
Memphis, Tennessee.



## ADDING LIFE TO YEARS—A HOPE

An editorial review by F. W. Niehaus in the *Nebraska State Medical Journal*, February, 1952, on "Arteriosclerosis—The Greatest Medical Problem," states the problem clearly in a few paragraphs describing distribution of the population by age, and the high standing of cardiovascular diseases in mortality statistics (51.1%), noting that "arteriosclerosis and hypertension caused 90.8 per cent of all deaths from cardiovascular disease" (1950 figures). These figures in themselves are thought-provoking and Dr. Niehaus goes on to say:

The problem then resolves itself as to what can be done to delay the development of arteriosclerosis, so that the individual may prolong his life span and his useful years. The aging process is relentless and modern medicine has made very meager progress to modify it. The biblical three score and ten years still holds sway in spite of the wonders of chemotherapy and the antibiotics.

The pathogenesis of arteriosclerosis has not been clearly defined. Heredity still remains an important factor. There may be reasonable speculation as to whether this is a specific quality of the chromosomes or whether it is due to family environments and food habits. From the present trend of research it would seem that nutrition may be the chief factor of approach to its elucidation. The effect of obesity in vascular disease is pretty well established. Many cases of hyper-

tension respond well to weight reduction. Diabetes is less frequent and better controlled in normal or below normal weight. Both of these diseases are recognized as accelerators of arteriosclerosis. Latest research in this subject is largely devoted to the relationship of cholesterol and lipoprotein metabolism to atherosclerosis. Some attempts have been made to apply this knowledge to human disease. Homan has published a diet manual on low fat and low cholesterol diets.

Further experience will be necessary to establish the validity of these observations. In our present state of knowledge it seems that whatever may be achieved in the control of atherosclerosis will be through nutrition, as having some influence as a curative measure, but being most effective as life long food habits. Our present knowledge of nutrition justifies the hope that this may be achieved for oncoming generations. There is also discussion regarding the influence of lipotropic substances such as choline, inositol and methionine, in removing sites of atherosclerosis. Morrison reports beneficial effects of their use in young individuals afflicted with coronary infarction. These, too, will need to be evaluated by further trial.

Finally, it is apparent that the effect of arteriosclerosis is of such magnitude as to justify an extensive research program in the hope that something may be accomplished to prevent its early appearance, and to check its ravages in later years, thereby not only "adding years to life, but life to years."

Apparently, we are still as young (or old) as our arteries.



## SCHOOL HEALTH CONFERENCE

THE Second Indiana Conference on Physicians and Schools met at the Claypool Hotel, Indianapolis, on September 26, 1951. It was sponsored by the Committee on School Health and Physical Education of the Indiana State Medical Association in cooperation with the Indiana Department of Public Instruction, the Indiana State Dental Association, the Indiana State Board of Health, the City and County School Superintendents Association and the Indiana School Board Members Association.

The need for the conference was expressed as follows: "The fact that school health programs in Indiana are functioning primarily upon the initiative of local school officials, teachers and nurses has brought to light the need for the establishment of a set of basic minimal standards for school health service programs at all educational levels."

The purpose was to establish standards by which every school corporation, regardless of size or financial and personnel resources, could place a school health program in action.

The registrants were divided into four groups and each of these groups devoted 45 minutes to a discussion of each of four subjects, "Health Appraisal," "Care and Follow Through," "Physical Education," and "Emotional Health."

Each discussion subject had a staff of officers, including a recorder. The following are reports submitted by the recorders of the respective groups.

### HEALTH APPRAISAL

Hester Beth Bland, *Reporter*

#### I. Need for a Program

- a. Such a need exists and the program should be developed and carried out by those who know how.
- b. Many people within the community are essential in working out a successful program.

#### II. How May More Efficient Teacher Observation Be Developed

- a. School administrators must be interested, and encourage teachers to be observant.

- b. Suggestions made by teachers should have careful follow-up.
- c. Teachers must be taught what to look for. (This may be opportunity for the public health or school nurse to plan in-service training for teachers. Some colleges and county health officers may provide such training classes.)
- d. A printed check list may serve as a guide for the teacher.

#### III. Some Suggestions for Developing a Dental Program

- a. School nurses, public health nurses, teachers, administrators, dentists, and parents are needed in the program.
- b. Dentists may volunteer their services.
- c. Defects revealed in the inspection should be charted and sent to the parents. The cards should be returned periodically to inform the teacher of corrections.
- d. To help overcome shortage of personnel, the dentist may train the teachers to make inspections.
- e. Students or teachers may assist with clerical work.
- f. Students should be motivated to appreciate dental health and be prepared for such inspections prior to their being made.
- g. Dental programs should be integrated with regular classroom activity.
- h. Areas without facilities or with limited facilities should: (1) contact local dentists for help; (2) use facilities of State Board of Health; (3) use teachers, trained by dentists, to make inspections.
- i. School administrators and dentists should cooperate to provide time for childrens dental appointments.

#### IV. Health Records

- a. Records should be cumulative, standardized, and accessible to teachers, administrators, and nurses.
- b. There is need for clerical help in keeping records but such personnel does not need medical training.



- c. The method for keeping records should be worked out locally.
  - d. Grades in physical examinations might be recorded on report cards.
- V. Pertinent Suggestions Relative to Initiating a School Appraisal Program
- a. School teachers and administrators should take the lead in enlisting the interest and help of those needed in a program.
  - b. A committee should plan the program.
  - c. There is need for parent education: (1) the health appraisal program is not a medical program; (2) the parent is responsible for the child's health.
  - d. A cooperative plan should be developed by doctors, dentists, school personnel and health agencies to provide the medical care a child needs.
  - e. Pupil motivation in all programs for health is very important.
  - f. There is need for in-service training for teachers.

#### VI. Things to Remember

- a. It is important for doctors, dentists, nurses, parents and school people to get together to talk about the needs of children.
- b. Cooperation is a result of understanding.
- c. There is need for enlarging and understanding the scope of "Health Appraisal."
- d. Interest, enthusiasm and a real desire to improve the health of children are sufficient to get a program started.

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### CARE AND FOLLOW-THROUGH GROUPS

MARGARET WARNER, *Reporter*

Discussion in this area was based on the assumption that the school child had had his physical appraisal at the school, or a physical examination by the school or family physician, and that certain recommendations had been made regarding physical deviations.

It was agreed that screening and diagnosis are not enough.

*Three kinds of medical care were discussed:*

1. Short-term or emergency care.
2. Long-term medical care involving specific procedures progressively carried out.
3. Care of the physically handicapped or exceptional child.

*Responsibilities of parents, schools and communities were discussed.*

#### 1. *Parents.*

It was agreed that nothing could be accomplished without the understanding and cooperation of parents. It was felt that parents often need to be prepared to be receptive to changes and procedures pointed out by the physician, and that parent education is often a long-term process. Although it was recognized that group education is essential to create general understanding of health needs and problems, it was felt that to meet the personal health problem of a child, personal education of both parent and child is a must. It was agreed that nothing can take the place of home visits made by teacher and nurse to discuss the particular needs of an individual child.

It was pointed out that organizations such as the Congress of Parents and Teachers do much to pave the way for care and follow-through programs by regularly scheduling health programs in their annual calendars. Group meetings of this kind assist in preparing parent "receptiveness," and do much to create general understanding of the health needs of children.

#### 2. *Schools.*

The teacher in the classroom was named as the first line of defense in the health program of the school, including follow-up, because of her daily contact with students. School administrators were charged with the responsibility of the administration of the total school health program. No specific recommendations were made in this area because of the variance in facilities and resources over the state. The public health nurse and/or the school nurse were named as key people in the care and follow-through program. The nurse was charged with the responsi-

bility of teaching the teacher what to see and what to do in certain incidences, and to act as a liaison between home, school and physician. It was suggested that the school physician, as well as the nurse, has responsibility for parent and child education, and to act also as a liaison between home, school and family physician.

### 3. *Community.*

It was felt that the community itself has a large role to play in the care and follow-through aspect of the school health program. Willingness to cooperate was cited as the keystone for the success of the program. It was agreed that each community should know what its facilities are and to find ways to assist in providing corrective medical care when parents are unable to carry the load. Finance and transportation were cited as two ways in which community groups might assist.

#### *Local Community Organization*

It was felt that to spearhead the program, provide direction, and maintain public interest and support, each community should have a central group to assume over-all responsibility for the care and follow-through program. This central group, representing all groups concerned, might work out the guiding principles of the program, coordinate the efforts of the many agencies and organizations interested in the program, provide local leadership, and generate sustained community interest.

Discussion brought out that some Indiana communities now have such groups. Several community and school health councils include the corrective medical care needs of referred school children as one of their problems, as do certain county case conference committees. Many community groups now carry out specific medical care assistance programs, e.g., glasses, braces, etc., but in many communities there is no coordination of programs. This frequently results in overlapping of assistance offered in some medical care areas with no provisions for assistance in others.

#### *State Advisory Group*

For coordination of the total state program it was recommended that a state advisory com-

mittee be established to assist local communities in developing comprehensive care and follow-through programs, and to offer guidance and leadership as the program developed. It was generally agreed that local communities must assume responsibility for their own problems and programs, but that a central advisory committee would have a place in the total program.

### CONCLUSIONS

The feeling of the groups discussing the problem of care and follow-through seemed to be that as screening and diagnosis are not enough, care and follow-through are also not enough. It was emphasized that throughout the school health program, from screening to the final correction of physical, dental or emotional disability, education must be made a vital part of each experience. It was felt that the child should not only benefit from remedial care, but know *how* he benefits; to learn that health is more than the absence of disease or disability; to know that health is a condition which affects his attitude toward life and contributes to his full enjoyment of life.

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### PHYSICAL EDUCATION

MALCOLM J. McLELLAND, *Reporter*

In summarizing the many thoughts and ideas expressed during the conference we might logically begin with the generally strong feeling of the group that while standardization of terminology was important, there was nothing wrong with the definition of physical education—possibly our philosophy could stand some re-evaluation.

The implication that there seemed to be imbalance in the physical education program in relation to athletics seemed to be prevalent. The very positive suggestion that evolved from the thinking was that athletics should be an outgrowth of a good physical education program—it is a reward for the ones who excel—it is a part of a physical education program as we know it. The suggestion that emphasis be placed on activities which have carry-over value was a timely one.

Much was said regarding the importance of providing opportunities for the handicapped child. A well-rounded physical education pro-



gram should provide this. We must remember that the child with a mild handicap needs and wants physical education programs which permit him the opportunity to perform within the limits of his capabilities. Care should be taken never to exploit the handicapped child. What we seem to need most is synchronization of effort so as to obtain maximum results, and not lost motion, which is likely to result from improper administrative handling of these problems.

An area receiving much consideration was that of relationships. What are the individual responsibilities, and what are the mutual responsibilities necessary in a successful physical education program? The following items were considered the real needs for a good program:

1. Need for more medical supervision.
2. Need for medical examinations for physical education participants, as well as for athletes.
3. Need for a mutual "give and take" attitude among physicians, teachers, and nurses.
4. Need for some planned screening for the purpose of assisting the physician.
5. Need for a board of doctors to consider certain referrals previously sorted out by the nurse—those who cannot or do not take physical education.
6. Need for an explanation of the objectives of physical education, as well as the proper use of facilities for the physician. Such interpretation might bring about better understanding and cooperation.
7. Need for parents who feel a responsibility for knowing what constitutes a good physical education program.
8. Need for re-evaluation of the mass excuses sometimes given by physicians to children releasing them from physical education classes.

The position of physical education in the total school health program is basically vital. The consensus was that a good program in the elementary grades would help to make a more adequate program for the upper levels even more demanding.

A well-balanced program of physical education cannot be had as long as athletics is con-

sidered by some separate and autonomous. A good program might eliminate the desire on the part of some children to seek excuses from physical education. It must be remembered that maybe the child who is constantly desiring excuses might be emotionally inadequate rather than physically incapable.

In summary, a good physical education program coupled with a good medical examination, along with fine physician, teacher, and parent cooperation may give us what seems to be a basic essential if we are to have physical education take its proper place in the school health program. Understanding, cooperation, and constant efforts to improve are vital.

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## EMOTIONAL HEALTH

REUBEN D. BEHLMER, *Reporter*

Herbert McMahan, M.D., gave a few brief remarks at the beginning of each session; pointing out what is meant by emotional health and then tracing the probable causes of emotional conflicts, also some signs portrayed in behavior patterns of those with emotional disturbances.

### QUESTIONS FROM THE FLOOR:

Q. Can teachers go into homes and confer with parents?

A. Yes, but they must use tact in convincing the parents their children are in need of special care and guidance.

Q. Are teachers capable of screening children with emotional problems?

A. Yes, to a certain degree.

Q. Do teachers promote emotional conflicts?

A. It is conceivable that teachers might do this, especially if they themselves exemplify emotional tension in a class, or expect a pupil to measure up to a level of accomplishment for which he does not have the inherited capacity.

Q. Can emotional disturbances be prevented by the teacher?

A. By and large, no. There are many factors beyond a teacher's control. Unfortunately, we have no penicillin for emotions. This places a premium on the detection of

emotional disturbances as early in life as possible. RANDOM COMMENTS AND STATEMENTS

Q. At what educational level should teachers be given in-service training?

A. Teachers of all levels need training. There is no set age at which emotional disturbances occur.

Q. How much do grades contribute to emotional disturbances?

A. There was considerable sentiment that it was wrong to pass a child just to keep him progressing. Sooner or later a child will know he is not deserving of promotion and this will cause conflicts. On the other hand, the frustration of failure for years is very bad. Probably the most important thing a teacher should know and recognize is the "Why" of the failures. A pupil with a mental capacity unable to cope with school work will probably be much happier and better adjusted out of school doing some job of which he is capable.

Q. When a child is found with emotional disturbances, what can we do?

A. This is obviously a medical problem. If nothing organic is found, it might be well to send him to a psychiatrist. It should not be overlooked, however, that the family doctor can often do a lot. He can go into the home and discuss with the family many situations that would be difficult for anyone else.

One very promising bit of help can be had from Child Guidance Clinics being established over the state. At present, clinics are at South Bend, Gary, Fort Wayne, Evansville, Indianapolis, and one Traveling Clinic.

1. Classroom enrollments are too large.
2. The kindergarten and first grade teachers play an important role in the educational system.
3. Team work is necessary to meet emotional problems. The team should consist of a Physician, Nurse, Teacher and Psychiatric Social Worker.
4. Stable homes would eliminate many emotional conflicts.
5. The mental health of a teacher is very important.
6. First grade teachers might do well to stagger the days of entrance into school. Portions of each group could enroll each day.

#### CONCLUSIONS

- I. The teacher does play an important role in emotional health. One responsibility is to detect emotional problems in her students. Her responsibility is to refer to proper channels for follow-up.

A second major responsibility is to have the right kind of mental health herself.

- II. To accomplish much the entire mental health problem requires team work of the school administration — teacher, nurse, physician, psychiatric social worker, psychiatrist, etc.
- III. Effort is being made by the medical profession to establish clinics throughout the state which can be of service to local communities.

The Indiana Academy of Ophthalmology and Otolaryngology will hold its annual meeting in South Bend on the campus of the University of Notre Dame, April 30 and May 1, 1952. Guest speakers will be G. O'Neil Proud, M.D., University of Kansas, and Harold G. Scheie, M.D., of Philadelphia.

All physicians practicing ophthalmology and otolaryngology are cordially invited to attend. For further information address: John R. Swan, M.D., 915 Hume Mansur Bldg., Indianapolis 4.



# The Fourth Estate Looks At Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

## UNCLE SAM'S MEDICAL MESS

Indianapolis has every right to be proud to be the home of the spanking new \$8,000,000 Veterans Administration Hospital which was dedicated Sunday. It is a splendid addition to the nation's medical facilities, and its location adjacent to the Indiana University Medical Center adds to the value of the latter.

Nevertheless this new hospital serves to re-emphasize the need for drastic reforms in the Federal medical setup along the lines recommended two years ago by the Hoover Commission.

For one thing, the Hoover survey found shocking misuse of the congressional authority which allows VA hospitals to treat nonservice-connected cases provided accommodations are available beyond the needs of service-connected cases. The commission learned that in one year 87 per cent of VA cases were nonservice-connected! That is one of the big reasons why Federal medical services are costing more than \$2,000,000,000 a year.

By abusing the authority given it to treat nonservice-connected disabilities, the empire-building VA has been able to show "cause" for the construction of more and more new hospitals. The heavy load of nonservice-connected cases constitutes a form of socialized medicine involving obligations to the 19,000,000 Americans who are veterans. Yet Congress never intended that the government become obligated for the permanent medical care of every person who ever served in uniform. It merely intended to prevent bed space unneeded for service-connected cases from being unused.

Moreover, while the VA has been building expensive new veterans hospitals, military hospitals have been closed. One of the insane features of the present jumble of Federal medical activities is that five large and more than 30 smaller government medical systems operate independently of one another, and often in fierce competition. Much waste and inefficiency could be eliminated, for example, by simply doing away with the artificial distinctions as to the particular types of beneficiaries for which Federal hospitals can care.

The Hoover Commission has provided a solution to Uncle Sam's medical mess. It is to streamline the government's medical agencies into a Federal "Department of Health" with jurisdiction over the

management, purchase, supply and construction of all the agencies which now go their merry independent way in defiance of the need for economy and efficiency. So far Congress has failed to act and has been under heavy political pressure against acting. Friends of the Hoover Commission program should let their senators and representatives hear from them.

*Indianapolis Star*

## THE DOCTORS SALUTE AN IDEAL OF SERVICE

Wonder drugs, miracle surgery and atomic tracers are all very well. But if we thought they mean a medical profession completely streamlined, remote and specialized down to the very eyebrow, we'd feel bad. For that would mean losing the heroic flavor and dedication of the family doctor, the old G. P., guide, philosopher and friend to everybody in the household from cradle to grave. It would mean the end of a saga of eager and unquestioning service, represented today by Dr. A. C. Yoder of Goshen, Indiana. The American Medical Association has just honored him as the Family Doctor of 1951.

We hope the A.M.A. keeps on forever picking the family doctor of the year. Pretty soon, however, those who were cast in the authentic mold of pioneers, like Dr. Yoder, will be passing out. Sterile clinics full of the proper gadgets will move to the cross-roads. More and more roads will be smoothed for eight-cylinder cars, or at the very least a jeep, to bear the healer in speed and comfort to his destination, almost on the breath of an emergency call.

But while they last, the likes of Doctor Yoder deserve all honor. This year's paragon of family doctors qualifies on all counts. His first operation was an appendectomy performed on a kitchen table. Before he could buy a horse and buggy, he made his calls on a bicycle. His words are the sage and pungent fruits of loving ruminations. And at 84, he is still at it, loath to quit while a single person still has need of him. We join his colleagues and his community in saluting him, not only for himself but also for the ideal he represents.

*—Louisville Courier-Journal.*

## News Notes

### ANNUAL CANCER SYMPOSIUM

Indiana University Medical Center

9:15 a.m., Wednesday, April 2

Registration will be at 8:30 a.m. in the School of Medicine — no fee — program open to all physicians. All sessions will be held in the auditorium of the Medical School.

Physicians attending can obtain lunch at the Riley hospital cafeteria immediately following the close of the morning session.

Adequate parking space available in the rear of the Medical School.

This is the fifth annual Symposium on Malignancy, presented as a part of the postgraduate program of the School of Medicine and is offered with the cooperation of the Indiana Cancer Society which has also participated in previous programs. The program this year is devoted to the subject: Cancer of the Breast.

The eight speakers participating in the symposium program are widely recognized authorities in the cancer field and were selected to present a well-rounded program on the various aspects of this particular type of malignancy.

On the evening preceding the Symposium, Tuesday, April 1, the eight speakers will participate in a roundtable discussion of Cancer—not limited to any one phase—which will constitute the seventh in the second annual series of Telephone Seminars.

All physicians are invited to submit written questions in advance for presentation to the panel. These questions may deal with any phase of cancer and as many of them as time will permit, will be discussed. The questions should be addressed to the: Cancer Committee, Indiana University Medical Center, 1040 - 1232 West Michigan St., Indianapolis 7.

The Telephone Seminar program will be presented from the auditorium of the School of Medicine and all interested physicians are invited to attend in person. The program begins

promptly at 8 p.m. and the audience should be seated prior to that time.

This program, one of the regular series presented by the School of Medicine and the Indiana State Medical Association, also has the support of the Indiana Cancer Society.

#### PROGRAM

"The Relationship Between Histologic Types of Breast Cancer and Prognosis." Lauren V. Ackerman, M.D., Department of Surgery, Washington University School of Medicine, St. Louis.

"Does Carcinoma Arise in Pre-Existing Benign Lesions of the Breast?" Shields Warren, M.D., New England Deaconess Hospital, Boston.

"How to Manage Chronic Cystic Mastitis." Murray M. Copeland, M.D., Professor of Oncology, Georgetown University Medical Center, Washington, D. C.

"The Diagnosis of Breast Cancer—Early and Late." Eugene M. Bricker, M.D., Department of Surgery, Washington University School of Medicine, St. Louis.

"When is Carcinoma of the Breast Operable?" Cushman D. Haagensen, M.D., Department of Surgery, Columbia University College of Physicians and Surgeons, New York City.

"Radical Mastectomy—Its Criteria and Uses." Grantley W. Taylor, M.D., 264 Beacon Street, Boston.

"The Use of Radiation Therapy in Breast Cancer." U. V. Portmann, M.D., Department of Radiology, Cleveland Clinic.

"The Office Management of Advanced Breast Cancer." Ira T. Nathanson, M.D., Massachusetts General Hospital, Boston.



TO ALL MEMBERS OF THE INDIANA STATE MEDICAL ASSOCIATION :

The Fourth Annual Scientific Session of the Indiana Academy of General Practice will be held at the Hotel Antlers, Indianapolis, on Tuesday and Wednesday, April 15 and 16, 1952.

The program of this meeting is printed below. We feel it is an outstanding program by outstanding medical teachers of National prominence. It is designed to appeal to all the physicians of Indiana and is part of the program of I.A.G.P. to make top flight Post Graduate education available to its members and all other physicians of the State.

The Academy invites *All* members of the Indiana State Medical Association to attend this meeting. There is no registration fee for anyone, whether a member of the Academy or not. Our sole aim is to present a fine program to as many physicians as will come.

A splendid group of Technical Exhibitors will have a display of the latest things in pharmaceuticals, books, equipment, business services, etc.

We believe we are offering you a meeting you will be glad you attended. Won't you come and see for yourself?

Sincerely,

CLARENCE H. ROMMEL, M.D.,

President, I.A.G.P.

## PROGRAM

### FOURTH ANNUAL SCIENTIFIC SESSION

#### *Indiana Academy of General Practice*

#### **TUESDAY, APRIL 15**

- 1:00 P.M. "Office Gynecology"—Sprague Gardiner, M.D., Indianapolis
- 2:00 P.M. "Counselling on Family Relations"—Dr. Evelyn Duvall, Chicago
- 3:30 P.M. "The Irritable Colon"—Wilmer Wirts, M.D., Jefferson Medical College, Philadelphia
- 8:00 P.M. THE FOUNDERS LECTURE: "Diagnosis and Treatment of Acute Toxic Nephrosis"—Francis D. Murphy, M.D., Marquette University  
(Joint meeting Indianapolis Medical Society)

#### **WEDNESDAY, APRIL 16**

- 9:30 A.M. "Management of Hypertension"—Edward Fries, M.D., Georgetown University, Washington, D. C.
- 10:30 A.M. "Treatment of Acute Cardiac Emergencies"—Tinsley Harrison, M.D., (American Heart Foundation), University of Alabama, Birmingham
- 12:00 Noon LUNCHEON—Speaker, Mr. Eugene Pulliam, Publisher, Indianapolis Star-News
- 1:30 P.M. "Therapeutic Gems"—Panel—Francis P. Jones, M.D., Moderator, Indianapolis
  - (a) "A.C.T.H. and Cortisone"—Glen W. Irwin, M.D., I.U. Medical Center
  - (b) "Resins"—Bill Martz, M.D., Lilly Research Laboratories
  - (c) "New Drugs"—Don Wolfram, M.D., Indianapolis
  - (d) "Treatment of Peptic Ulcer with New Drugs"—Bernard Rosenak, M.D., Indianapolis
- 2:30 P.M. "Treatment of Coronary Disease"—W. D. Stroud, M.D., Philadelphia
- 4:00 P.M. "Diagnosis of Pelvic Malignancies"—Charles H. Hendricks, M.D., I. U. Medical Center (Indiana Cancer Society)
- 5:00 P.M. Question and Answer Period—Speakers of Entire Program Participating
- 6:30 P.M. BANQUET
  - Speaker—GEORGE W. CRANE, M.D., Ph.D., syndicated newspaper writer of "The Worry Clinic," appearing daily in The Indianapolis Star.

**THE NORTHERN TRI-STATE POSTGRADUATE  
MEDICAL ASSOCIATION MEETING**

April 15, 1952

Amphitheater of Engineering Building  
University of Notre Dame  
Notre Dame, Indiana  
(South Bend)

- 8:00- 8:45 Registration
- 8:45- 8:50 Greeting — L. G. Erickson, M.D., President of the Saint Joseph County Medical Society. Introduction by James E. McMeel, M.D., President of the Northern Tri-State Medical Association.
- 8:50- 9:00 Welcome to Notre Dame—Reverend J. J. Cavanaugh, C.S.C., President of the University of Notre Dame.
- 9:00- 9:40 "Treatment and Management of Burns"—W. H. Steffensen, M.D., Grand Rapids, Michigan.
- 9:40-10:30 "The Management of the Arteriosclerotic"—Wm. A. Thomas, M.D., Chicago.
- 10:30-11:00 "Your Feet and Mine"—Gordon W. Batman, M.D., Indianapolis.
- 11:00-12:00 "Pathological Conference"—Associates of the South Bend Medical Laboratory, South Bend.
- 12:15 Luncheon in Faculty Dining Hall. Speaker—Dr. Clarence Manion, Dean of the School of Law, Notre Dame University—"The Key to Peace."
- 2:00- 2:40 "Angiography." Motion Picture prepared by the Searle Company.
- 2:40- 3:20 "Mechanism of Loss of Consciousness and Its Management" (Head Injuries)—Edgar A. Kahan, M.D., Ann Arbor, Michigan.
- 3:20- 4:00 "Proctology"—Louis Hirschman, M. D., Detroit, Michigan.
- 4:00- 4:15 Business Meeting.
- 4:15- 5:15 Tour of The LOBUND Institute for Research in the Life Sciences under the direction of James A. Reyniers, Director of Lobund at Notre Dame University.

All physicians are invited. For Hotel Reservations April 14 contact Joseph J. Lang, M.D., 730 J.M.S. Building, South Bend.

*Dr. Daniel A. Gard* has taken over the location of *Dr. Gale E. Dryden*, at 5 South Belmont Avenue, in Indianapolis. Doctor Dryden is now with the U. S. Public Health Service.

*Dr. J. C. Travis*, of Indianapolis, has closed his office and is taking a residency in psychiatry at the Logansport State Hospital.

**REGULAR CORPS EXAMINATION FOR  
MEDICAL OFFICERS**

A competitive examination for appointment of Medical Officers to the Regular Corps of the United States Public Health Service will be held on June 3, 4, and 5, 1952. Examinations will be held at a number of points throughout the United States, located as centrally as possible in relation to the homes of candidates. Applications must be received no later than April 30, 1952. Application forms and additional information may be obtained by writing to the Surgeon General, United States Public Health Service, Federal Security Agency, Washington 25, D. C. Attention: Division of Commissioned Officers.

**NORWAYS FOUNDATION HOSPITAL**

Rodney W. Hemsworth has been named administrator of Norways Foundation Hospital, Indianapolis. Mr. Hemsworth was formerly employed for three years as administrative assistant at the General Hospital Division of the Medical Center at Jersey City, New Jersey. Previous to that he was with the University of Minnesota Hospitals for six years. The new administrator received a Bachelor of Business Administration degree and a Master of Hospital Administration degree from the University of Minnesota. He is a Nominee of the American College of Hospital Administrators. A former Marine, Mr. Hemsworth served thirty-four months in the South Pacific. He is now a Hospital Administrative Officer in the United States Air Force Reserve.

*Dr. Hardin Ritchey*, who has been in residency at Norways Hospital, in Indianapolis, is now associated with the Silver Hills Foundation at New Canaan, Connecticut.

*Dr. John E. Meihaus*, of Indianapolis, has moved to Los Angeles, where he is stationed with the Veterans Administration.

*Dr. Robert H. Cusack*, who has been in general practice in Indianapolis, has moved to California, where he will be associated with a clinic in Los Angeles. He is a 1949 graduate of Indiana University School of Medicine.



Veterans Administration has announced it will pay a regular dividend of \$200,000,000, beginning in March, 1952, to approximately 5,000,000 holders of National Service Life Insurance.

Policyholders who wish to receive their 1952 dividend in cash must so notify VA, under Public Law 36, 82nd Congress.

Policyholders who do not so notify VA, under this law, will not receive their dividend in cash. Instead, it will be used by VA to pay the premiums becoming due after the dividend is payable, if the policyholder fails to pay such premiums.

VA said it is mailing a special form to all eligible policyholders which they may use to request cash payment, if that is their desire. However, any type of written request for cash payment will be acceptable, VA said; but, in such cases, the policyholders are cautioned to give their full name and address and their insurance numbers so that their accounts may be identified easily and quickly.

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*Dr. Howard B. Davis* has opened an office for the general practice of medicine in Vincennes. A graduate of the University of Louisville School of Medicine, he took postgraduate work at Indiana University, and interned at Brooke General Hospital at San Antonio, Texas. Doctor Davis is a World War II veteran.

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*Dr. Julius Glick*, of Chicago, has moved to Walkerton, where he has taken over the practice of *Dr. C. D. Linton*, who will take a two-year residency in anesthesiology at Indiana University School of Medicine. Doctor Glick is a graduate of the University of Illinois School of Medicine, and interned at Cook County Hospital in Chicago. He is a veteran of World War II.

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*Dr. Eugene L. Hendershot* has become associated with *Dr. Keith T. Meyer* in the practice of roentgenology at Evansville. Doctor Hendershot is a 1946 graduate of Indiana University School of Medicine, and interned at Methodist Hospital in Indianapolis. Following this he entered the service.

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*Dr. John Ralston* has opened an office for the practice of medicine at 6349 Guilford Avenue, in Indianapolis.

On April 3, 4, and 5, 1952, the Frank E. Bunts Institute and the Cleveland Clinic Foundation will present a continuation course for physicians on "*The Diagnosis and Treatment of Malignant Disease*." Dr. Freddy Homburger, Research Professor of Medicine, Tufts College Medical School, Boston, will give the evening lecture on April 4. The other guest speakers will be Dr. Allan C. Barnes, Professor of Obstetrics and Gynecology and Chairman of the Department, Ohio State University, College of Medicine; Dr. Brown M. Dobyns, Associate Professor of Surgery, Western Reserve University School of Medicine, Cleveland; and Dr. Thomas D. Kinney, Director of Laboratories, Cleveland City Hospital and Professor of Pathology, Western Reserve University School of Medicine, Cleveland.

Inquiries regarding the complete program and registration may be addressed to the Frank E. Bunts Educational Institute, 2020 East Ninety-third Street, Cleveland 6, Ohio.

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*Dr. William J. Miller*, of Fort Wayne, has been appointed to a three-year fellowship in internal medicine at the Mayo Clinic. He plans to resume his practice in Fort Wayne upon completion of his postgraduate work. He has been practicing in Fort Wayne since his release from the Air Force in 1948.

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*Dr. Lloyd R. Studebaker* has opened an office for the practice of medicine in LaGrange. He has formerly practiced at New Paris and Goshen.

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*Dr. Robert L. Tyler*, a graduate of the College of Medicine at Los Angeles, California, has joined the staff of the Linvill Memorial Clinic at Columbia City. Following his graduation, in 1945, he took postgraduate training in internal medicine at Boston City Hospital and at Gersinger Memorial Hospital, at Danville, Pennsylvania.

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*Dr. Frank C. Waltz* has opened an office for the general practice of medicine and surgery at Mentone. A veteran of four years service in the Navy, Doctor Waltz graduated from Indiana University School of Medicine in 1950, and took postgraduate training at the Methodist Hospital in Indianapolis.

**A.M.A. WASHINGTON OFFICE NEWS****NEW FEDERAL POLICY ON HEALTH AND WELFARE PLANS IN UNION CONTRACTS**

Wage Stabilization Board has adopted a policy allowing *automatic approval of health and welfare plans in union contracts*, providing they meet certain criteria, thereby permitting thousands of held-up plans to go into effect. The WSB ruling was required to determine what benefits could be allowed over and above official wage ceilings. The policy represents a compromise between labor-public and industry recommendations of a special panel.

The policy, set forth in *General Wage Regulation 19 and Resolution 78*, covers benefits for: surgical expense, hospital expense, temporary disability, in-hospital medical expense and death benefits on a group basis, including accidental death and dismemberment benefits.

Details of any new or revised plans must be furnished WSB in Washington on special forms. Thirty days after this notification, the plan may go into effect if it is limited to:

*Surgical expenses:* Partial or complete payment for surgical expenses for any injury or illness (including surgical care in obstetrical cases) and not covered by compensation laws. Board allows fees not in excess of (a) usual Veterans Administration prepayment surgical plan or (b) standard maximum \$200 commercial insurance fee for an operation. Board rules out dental service or unusual types of benefits like plastic surgery for beautifying.

*Hospital expenses:* Partial or complete payment for any injury or illness not covered by compensation laws for (a) hospital room and board charges for other than private accommodations and (b) such miscellaneous charges as laboratory and X-ray exams, drugs, medicines and operating rooms. Ruled out are special nursing, full payment for private room, blood plasma, treatment for tuberculosis, nervous or mental cases for periods exceeding 30 days for each confinement.

*In-hospital medical expenses:* Partial or complete payment of medical charges for any hospitalized injury or illness, other than those charges covered by surgical or hospital expense

benefits, not covered under any compensation law. Ruled out are (a) payments to physicians in excess of \$5 per day, (b) if graduated visits, payments after the first few in excess of \$4 a day and (c) reimbursement for more than 70 days during which there were visits.

The announced policy contains these additional regulations:

1. If a plan exceeds provisions stated above, the non-disputed points may be put into effect after the 30 days, with the disputed points held up until WSB or its staff makes a ruling on them; no time limit set on ruling.
2. An employer may extend an existing plan without modification to (a) smaller employment units within the same establishment or (b) from one group of employees in one geographical unit to another geographical unit.
3. If employee pays 40 per cent or more of cost, WSB approval is not required regardless of benefits provided by plan. In this case, however, dependents may not share in the additional benefits.
4. Plans in effect on or before January 25, 1951, are automatically approved by WSB, regardless of benefits.
5. Regulations will be reviewed regularly and may be revised.

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**AMA TRUSTEE APPEARS BEFORE HOUSE COMMITTEE ON MEDICAL PHASE OF UMT**

Dr. F. J. L. Blasingame, AMA trustee, appeared before House Armed Services Committee on medical aspects of Universal Military Training. Among the points made in his prepared testimony were (a) need for deferment of medical students from serving in the reserve until completion of schooling, (b) use of civilian physicians on fee basis or reserve personnel in making physical examinations at all stages of training, and (c) creation of a national civilian board to determine medical and allied personnel needed for UMT.



**DEFENSE DEPARTMENT, UMT COMMISSION  
SUPPORT AMA ON MEDICAL STUDENT  
DEFERMENT**

Defense Department and National Security Training Commission are in agreement with *American Medical Association* that pre-medical and medical students, after six months of Universal Military Training, should be deferred from service in the reserves until completion of their schooling and internships. The two agencies presented their views before the House Armed Services Committee, which is holding hearings on bills to implement UMT. If Congress puts UMT into effect, it will be run by Defense Department but supervised by the Civilian Commission.

For the first year at least, deferments would not be an important factor, as Defense Department contemplates starting out with only 60,000 18-year old volunteers. Eventually as many as 800,000 inductees could be trained annually.

Prior to opening of the hearings, AMA urged the Commission to support *deferment of reserve service through internships and in some cases residencies*. Thus men would serve their full seven and one-half years in the reserves *as physicians, not as students*. In subsequent testimony before the Committee, Karl T. Compton (Ph.D.), a Commission member, agreed with the AMA, saying “. . . recall to reserve duty could well be held in abeyance until schooling was completed.” A Commission spokesman explained that this meant deferment through internship but not necessarily residency.

Assistant Secretary Anna Rosenberg testified that Defense Department was opposed to blanket deferment of college students from reserve service after completion of basic training. She said later, however, that the Department believed *medical students should be allowed to finish their education without interruption*, once they have completed the six months of training.

. . . PRESIDENT TRUMAN advocates “far greater” quantities of medical supplies in reserve for civil defense and has promised state civil defense directors he will seek more funds from Congress for such purposes. Directors discussed plans for recruiting 17.5 million civil defense volunteers at 3-day meeting.

LODGE PROPOSES EXTENDING SOCIAL SECURITY TO LAWYERS. Senator Henry Cabot Lodge, Jr., (R.-Mass.) has introduced a bill (S2481) to extend voluntary social security coverage to lawyers. He explained that currently social security is available to all self-employed persons with the exception of farm operators and a comparatively small professional group. Included in the exempted group are physicians and dentists, as well as lawyers engaged in private practice. The Senator gave as two major arguments against extension that (a) as a class, lawyers are supposed to be able to provide security for themselves, and (b) they generally continue practice after 65, so for a number of years would be deprived of the benefit for which they paid. Senator Lodge listed eight economic and social reasons why he thought lawyers should be allowed to participate in federal old age and survivors insurance.

On April 4-5-6, 1952, at Pittsburgh, Pennsylvania, **The American College of Allergists** will offer an instruction course in allergy. To insure complete coverage, the College has called in some 60 well-known authorities in the field to give addresses, clinical talks and demonstrations. The program has been designed for physicians in other fields of practice, especially those in general practice, that they may learn to recognize and manage the allergic component in the complaints of their patients.

For further information and a copy of the program, write the office of The American College of Allergists, LaSalle Medical Building, Minneapolis 2, Minnesota.

## *Indiana University News Notes*

Activities got under way the first of January leading to the construction of the long discussed Medical Science Building which will be one of the major additions to the further development of the Medical Center.

A twelve-member Medical Science Building Planning Committee has been named and is meeting at regular intervals to outline the plans. Dean John D. VanNuys of the Medical School and Dean Maynard K. Hine of the Dental School are ex-officio members of the committee, which is composed of Dr. D. E. Bowman, Dr. L. W. Freeman, Dr. Edwin Lawrence, Dr. John J. Mahoney, Dr. Edward W. Shrigley, Dr. Edward Smith and Dr. Randall Thompson from the School of Medicine, with the addition of Dr. Paul M. Harmon and Dr. Richard A. Webb of the School of Medicine faculty on the Bloomington Campus; and Dr. Drexell A. Boyd, Dr. John F. Johnston, and Dr. Grant VanHuysen of the School of Dentistry faculty.

An appropriation of \$125,000 was authorized by the Indiana General Assembly at its 1951 regular session for the planning of the Medical Science Building. The building will relieve badly congested classroom and laboratory facilities in the buildings housing the Dental and Medical Schools on this campus.

Beginning January 1 patient care in the University hospitals is now charged on the standard system of a basic rate which covers such services as bed, board, routine nursing and also routine care by other members of the house staff. This basic rate is from \$9.00 per day for Ward patients; from \$11.50 per day for semi-private patients; and from \$14.00 per day for private patients. To this basic charge will be added charges for x-rays, laboratory tests, drugs, etc. This is the method which is used in 95 percent of the hospitals over the country today.

Until this time, with the exception of private patients, the University hospitals have used an inclusive rate which covered all services required by the patient, regardless of the number of x-rays, laboratory tests, drugs, etc.

The change in the method was made following a long study on the part of University officials and conferences with the Welfare Department, Blue Cross and State Board of Accounts.

The new card-o-plate system, introduced recently, is operating smoothly in the Medical Center hospitals. Installation of the new system at a cost of approximately \$7,000 is expected to result in considerable time saving and increased efficiency in handling records on the patients.

Under this plan when a patient is admitted to one of the University hospitals, a metal plate similar to the charge-plate, used in many retail stores, is cut and attached to the chart. This plate is then used to stamp all drugs, x-ray, laboratory and other requisitions for that patient. Use of the stamp eliminates any possibility of mistake in spelling of names and is expected, in combination with the special forms now in use, to effect a material saving in time to physicians, nurses and other members of the staff.

New furniture for Newby Clinic at Riley Hospital, the gift of the Crosstown Merchants Association of Indianapolis has arrived and been placed in service. Funds for the gift resulted from the annual street fair sponsored by business firms in the vicinity of East 30th Street and Winthrop Streets in Indianapolis. The furniture makes a more cheerful and comfortable place in which to wait when patients come to the Riley Hospital clinics.

A Westinghouse television set with a 20-inch screen, a gift from the people of Bedford and Lawrence County, was delivered to Ward K in Riley Hospital in time for use during the holiday seasons. This is the second television set given to Riley by the Bedford and Lawrence County residents under a program inaugurated by the *Bedford Times-Mail*.



## Deaths

**J. Rudolph Yung, M.D.**, of Terre Haute, died suddenly in Phoenix, Arizona, on January 29. He was seventy-three years of age. He had practiced in Terre Haute for more than fifty-one years. He was a graduate of the University of Illinois College of Medicine in 1900. Doctor Yung was a member of the Vigo County Medical Society and the Indiana State Medical Association, and was a fellow of the American Medical Association.

**Samuel E. Dittmer, M.D.**, of Kouts, died on December 1, at the age of sixty-seven. He was a graduate of the Hahnemann Medical College of Chicago, in 1911, and had practiced continuously in Kouts since 1912. Doctor Dittmer was a veteran of World War I, and was a member of the Porter County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

**Clayton C. Campbell, M.D.**, formerly of Walton, died in Long Beach, California, on November 22, at the age of seventy-two. He graduated from the Central College of Physicians and Surgeons in Indianapolis in 1904 and practiced in Walton prior to World War I. He was a member of the Los Angeles County Medical Society, the California State Medical Association, and the American Medical Association.

**Joseph F. Casper, M.D.**, of Jasper, died on January 18 after a brief illness. He was sixty-three years of age. A 1910 graduate of the University of Louisville School of Medicine, he began practice in Jasper. Following his release from service in World War I, in 1923 he began practice in Louisville, where he remained until 1937, when he returned to Jasper, where he had practiced ever since. Doctor Casper was a member of the Dubois County Medical Society, the Indiana State Medical Association, and the American Medical Association.

**M. Joseph Coomes, M.D.**, of Shelbyville, died on January 6 as a result of injuries sustained in an accident. He was eighty-one. He graduated from the Louisville Medical College in 1892, and had practiced medicine for sixty years. He was a veteran of World War I, and was an honorary member of the Shelby County Medical Society and the Indiana State Medical Association, and a member of the American Medical Association.

**Thomas G. Graham, M.D.**, of Lafayette, was killed in an airplane accident on October 7. He was a graduate of the University of Louisville School of Medicine in 1933, and had practiced surgery in Lafayette since that time, with the exception of four years with the armed forces. He was forty-three years of age. He was a member of the Tippecanoe County Medical Society, the Indiana State Medical Association and the American Medical Association.

**James S. Niblick, M.D.**, of East Chicago, died suddenly on December 27, at the age of fifty-six. He graduated from the Chicago College of Medicine and Surgery in 1917, and had practiced in East Chicago since that time. Doctor Niblick was a member of the Lake County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

**James F. Openshaw, M.D.**, of Goodland, died in Indianapolis on January 23, at the age of forty-four. He was a 1936 graduate of Indiana University School of Medicine, and had practiced in Goodland since 1938. He was a veteran of World War II, and was a member of the Jasper-Newton County Medical Society, the Indiana State Medical Association, and the American Medical Association.

**Francis T. O'Leary, M.D.**, of Logansport, died on January 22, at the age of seventy-seven. After his graduation from the University of Nashville Medical Department, in Nashville, Tennessee, he began his practice in Logansport, where he had practiced ever since. He was a member of the Cass County Medical Society, the Indiana State Medical Association, and the American Medical Association.

**Cecil L. Eisaman, M.D.**, of Marion, died on February 10 at the age of fifty-two. A 1925 graduate of Indiana University School of Medicine, he practiced in Indianapolis from 1926 to 1942, when he entered the Navy. He had lived in Marion since his release from service in 1945.

**Benjamin F. Stickler, M.D.**, of Columbia City, died on January 18 at Indianapolis. He was sixty-seven. He was a graduate of Indiana University School of Medicine in 1911, and had practiced in Columbia City until he retired approximately one year ago.

## Society Reports

### INDIANA STATE MEDICAL ASSOCIATION

#### THE COUNCIL

January 13, 1952

The Council of the Indiana State Medical Association convened for its mid-winter meeting at 10:10 a.m. Sunday, January 13, 1952, in the Harrison Room of the Columbia Club, at Indianapolis, with Dr. W. U. Kennedy, chairman, presiding.

Roll call showed the following present:

#### Councillors:

First District.....Paul D. Crimm, Evansville,  
alternate and president-elect  
Second District.....A. G. Blazey, Washington  
Third District.....William H. Garner, New Albany  
Fourth District.....Charles Overpeck, Greensburg  
Fifth District.....M. C. Topping, Terre Haute  
V. Earle Wiseman, Greencastle, alternate  
Sixth District.....W. U. Kennedy, New Castle  
Seventh District.....Roy A. Geider, Indianapolis  
Don E. Wood, Indianapolis,  
alternate, and chairman,  
Legislative Committee  
Eighth District.....T. R. Hayes, Muncie, alternate  
Ninth District.....Wemple Dodds, Crawfordsville  
Harry E. Klepinger, Lafayette,  
alternate  
Tenth District.....William H. Howard, Hammond  
Eleventh District.....Elton R. Clarke, Kokomo  
R. W. Lavengood, Marion, alternate  
Twelfth District.....M. B. Catlett, Fort Wayne  
Myron L. Habegger, Berne, alternate  
Thirteenth District.....Kenneth L. Olson, South Bend  
G. O. Larson, LaPorte, alternate

#### OFFICERS:

J. William Wright, Indianapolis, president  
Roy V. Myers, Indianapolis, treasurer  
A. W. Cavins, Terre Haute, associate editor of  
THE JOURNAL  
Walter L. Portteus, Franklin, chairman, Executive  
Committee  
C. J. Clark, Indianapolis, member, Executive  
Committee  
Albert Stump, attorney  
James A. Waggener, executive secretary

#### GUESTS:

Wendell C. Stover, Boonville, A.M.A. delegate  
Robert H. Rang, Washington, A.M.A. alternate  
Cleon A. Nafe, Indianapolis, A.M.A. alternate  
J. Neill Garber, Indianapolis, chairman, Committee  
on Convention Arrangements  
William H. Lane, South Bend, chairman, Committee  
on Physician-Hospital Relationship  
Glen Ward Lee, Richmond, chairman, Committee on  
Civil Defense  
E. H. Clauser, Muncie, chairman, Screening Committee

On motion of Drs. Geider and Olson, minutes of the meetings of October 29 and 31, 1951, were approved as printed in the December, 1951, issue of THE JOURNAL.

#### Distribution of Information on Mutual Medical Insurance, Inc.

At the suggestion of Dr. Kennedy, and on motion of Drs. Howard and Garner, the Council approved of an information desk at each of the district meetings on which forms and printed material may be placed and where members may discuss Mutual Medical Insurance matters with Mutual Medical representatives.

#### District Meetings

District meetings were reported scheduled as follows for 1952:

First District.....  
Second District.....Linton, —  
Third District.....Spring Mill, —  
Fourth District.....Madison, —  
Fifth District.....Greencastle, May 14, 1952  
Sixth District.....Rushville, —  
Seventh District.....Indianapolis, May 13  
Eighth District.....Anderson, —  
Ninth District.....Crawfordsville, May 21  
Tenth District.....  
Eleventh District.....Kokomo, May 21  
Twelfth District.....Fort Wayne, May 27  
Thirteenth District.....Elkhart, November —

#### Reports of Councillors

Each councillor reported briefly on the activities and accomplishments in his district.

Dr. Catlett, Twelfth District, presented the suggestion of some of the members of his district that Blue Shield, or the "Doctor's Plan," might be called the "People's Plan."

#### Reports of Officers

Dr. J. William Wright, president, congratulated the Council on its excellent attendance.

Dr. Roy V. Myers, treasurer, presented the following report, compiled by George S. Olive and Company, certified public accountants, which was accepted by consent:

#### Treasurer's Report

January 9, 1952

The Council,  
Indiana State Medical Association,  
Indianapolis, Ind.

Gentlemen:

We have examined the accounts and financial records of the Indiana State Medical Association as of December 31, 1951, and the statements of income and expense, and fund balances for the year then ended, on a cash receipts and disbursements basis. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the account-



ing records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the accompanying statement of assets, all funds, and related statements of income and expense, on a cash receipts and disbursements basis, present fairly the position of the Indiana State Medical Association at December 31, 1951, and the results of its operations for the year then ended, in conformity with generally accepted accounting principles applied on a consistent basis.

Yours very truly,

Geo. S. Olive & Co.

Certified Public Accounts

#### Exhibit A

#### INDIANA STATE MEDICAL ASSOCIATION

#### Analysis of Increase in Assets, All Funds,

Year Ended December 31, 1951

TOTAL ASSETS, DECEMBER 31, 1951-----\$119,223.28

TOTAL ASSETS, DECEMBER 31, 1950----- 75,298.29

NET INCREASE ----- \$ 43,924.99

Arising from the following sources:

Excess of operating cash receipts over operating cash disbursements, year ended December 31, 1951:

General fund—exhibit C:

Receipts ---\$135,445.95

Disbursements --- 100,263.91

35,182.04

Add: Increase in petty cash 500.00

\$ 35,682.04

The Journal of the Indiana State Medical Association — exhibit D:

Receipts -- 41,413.30

Disbursements --- 35,354.10

6,059.20

Medical Defense fund—exhibit E:

Receipts --- 4,708.75

Disbursements --- 2,525.00

2,183.75

NET INCREASE ----- \$ 43,924.99

#### Exhibit B

#### INDIANA STATE MEDICAL ASSOCIATION

#### Statement of Assets, All Funds, at December 31, 1951

#### GENERAL FUND:

Cash on deposit—Exhibit C---\$40,715.55

Petty cash fund ----- 1,000.00

Investments:

U. S. Treasury bonds ----- \$ 5,000.00

U. S. Savings bonds ----- 36,000.00

41,000.00

Total general fund ----- \$ 82,715.55

#### THE JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION:

Cash on deposit—exhibit D--- 14,566.28

#### MEDICAL DEFENSE FUND:

Cash on deposit—Exhibit E--- 3,941.45

Investments:

U. S. Treasury bonds ----- 5,000.00

U. S. Savings bonds ----- 13,000.00

18,000.00

Total Medical Defense Fund 21,941.45

TOTAL ASSETS, ALL FUNDS—Exhibit A \$119,223.28

#### Exhibit C

#### INDIANA STATE MEDICAL ASSOCIATION

#### Comparative Statement of Cash Receipts and Disbursements, Years Ended December 31, 1951, and December 31, 1950

#### General Fund

	Year Ended		
	December 31, 1951	December 31, 1950	Increase (Decrease)

#### CASH BALANCE

#### AT

#### BEGINNING OF

YEAR	1951	1950	
	\$ 5,533.51	\$ 8,964.01	\$ (3,430.50)

#### RECEIPTS:

Membership dues	115,370.00	117,682.50	(2,312.50)
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Income from

exhibits	14,675.00	7,938.50	6,736.50
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Interest income	1,172.50	1,112.50	60.00
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Proceeds from matured bonds	4,000.00	1,000.00	3,000.00
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Egbert medical scholarship fund	200.00	100.00	100.00
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Centennial book fund	14.45	63.30	( 48.85)
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Miscellaneous income	14.00	----	14.00
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Postgraduate study fees	----	430.00	( 430.00)
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Krannert Nurse Scholarship fund	----	1,200.00	(1,200.00)
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Instructional courses	----	36.02	( 36.02)
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Total receipts

—Exhibit A	\$135,445.95	\$129,562.82	\$ 5,883.13
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#### BEGINNING BALANCE PLUS

CASH RECEIPTS	140,979.46	138,526.83	2,452.63
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#### DISBURSEMENTS:

Transfer of applicable portion of dues to The Journal of the Indiana State Medical Association

-----	10,896.00	11,004.00	( 108.00)
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Medical Defense Fund—Exhibit E	4,318.75	4,327.75	( 9.00)
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Purchase of securities	4,000.00	1,000.00	3,000.00
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Headquarter's office expense	21,155.03	21,106.05	48.98
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Publicity committee	1,703.55	730.37	973.18
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Public policy	2,374.83	6,846.60	( 4,471.77)
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Council	1,563.46	1,105.31	458.15
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Officers -----	1,893.40	2,897.51	( 1,004.11)
Annual session ---	11,800.25	7,399.85	4,400.40
Miscellaneous			
committees -----	8,985.21	9,898.97	( 913.76)
Federal insurance			
contributions tax	242.37	217.78	24.59
Indiana unemploy-			
ment compensa-			
tion and excise			
tax -----	421.31	435.58	( 14.27)
Refunds of dues--	----	38.00	( 38.00)
Refunds of exhibit			
rent -----	----	77.50	( 77.50)
Fifty-year club --	324.08	35.04	289.04
Increase in petty			
cash fund -----	500.00	----	500.00
Woman's Auxiliary			
to I.S.M.A. -----	77.13	218.35	( 141.22)
A.M.A. Coordinat-			
ing Committee--	29,950.08	64,883.75	(34,933.67)
A.M.A. dues -----	----	612.50	( 612.50)
General Practitioner			
Award -----	58.46	58.10	.36
Miscellaneous ----	----	100.31	( 100.31)

Total disburse-			
ments—Exhibit			
A -----	100,263.91	132,993.32	(32,729.41)

<b>CASH BALANCE AT</b>			
<b>END OF YEAR</b>	\$ 40,715.55	\$ 5,533.51	\$ 35,182.04

**Exhibit D****INDIANA STATE MEDICAL ASSOCIATION****Statement of Cash Receipts and Disbursements,  
Year Ended December 31, 1951**

The Journal of the Indiana State Medical Association  
BALANCE, JANUARY 1, 1951-----\$ 8,507.08

**RECEIPTS:**

Subscriptions—members—	
Exhibit C -----	\$10,896.00
Subscriptions—non-members ----	440.00
Advertising -----	28,979.97
Collections on accounts receivable	307.32
Single copy sales -----	226.00
Electrotypes -----	228.01
Sale of civil defense reprints-----	336.00

Total receipts—Exhibit A-----	41,413.30
	49,920.38

**DISBURSEMENTS:**

Salaries -----	\$ 7,600.00
Printing -----	23,735.75
Office postage -----	264.33
Journal postage -----	632.51
Advertising commissions -----	172.67
Electrotypes -----	940.96
Press clippings -----	125.86
Office supplies -----	247.35
Rent -----	480.00
Electricity -----	20.88
Telephone and telegraph -----	225.03
Federal insurance contributions--	112.56
Indiana unemployment compensa-	
tion and excise -----	224.98
Art work -----	75.00
Civil defense reprints -----	340.75
Miscellaneous -----	155.47

Total disbursements—	
Exhibit A -----	35,354.10

<b>BALANCE, DECEMBER 31, 1951—</b>	
<b>EXHIBIT B -----</b>	<b>\$14,566.28</b>

**Exhibit E****INDIANA STATE MEDICAL ASSOCIATION****Statement of Cash Receipts and Disbursements,  
Year Ended December 31, 1951  
Medical Defense Fund**

BALANCE, JANUARY 1, 1951-----\$1,757.70  
**RECEIPTS:**

Transfer of applicable portion of	
dues from the general fund—	
Exhibit C -----	\$4,318.75
Interest income -----	390.00

Total receipts—Exhibit A-----	4,708.75
	6,466.45

**DISBURSEMENTS:**

Malpractice fees -----	725.00
Attorney fees -----	1,800.00

Total disbursements—Exhibit A-----	2,525.00
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**BALANCE, DECEMBER 31, 1951—Exhibit B--\$3,941.45**

**Elections for 1952**

1. *Chairman of the Council.* On ballot vote, Dr. Wemple Dodds was elected chairman of the Council for 1952.

2. *Executive Committee members.* Dr. W. L. Portteus and Dr. C. J. Clark were re-elected members of the Executive Committee for 1952.

**Unfinished Business**

1. *Resolution approved by House of Delegates calling for the introduction of a bill in the General Assembly "that would make the Chief of Staff of County Hospitals, who is elected annually by the hospital staff, a regular or legal fifth member of the hospital's Board of Governors"* was discussed by Dr. Lane, chairman of the Committee on Physician-Hospital Relationship. "This subject came up for discussion before our committee in November. . . . We think the Council should discuss this situation at length and perhaps delay any action as far as legislation is concerned. This very thing came up at the Clinical Congress of the American College of Surgeons. . . . They are all unanimous in their belief that a doctor should not be on the Board of Governors of a hospital. If we can effect proper liaison with the organized medical staff and the Board of Governors of the hospital, I think that would be a much better way to manage our affairs and to do justice to our work."

Following comments by Drs. Dodds, Rang, Garner, Wiseman, Mr. Stump and Dr. Geider, in which the feeling was expressed that such legislation would not be a good thing, on motion of Drs. Geider and Olson the Council voted to refer this matter to the interim session of the House of Delegates.

2. *Civil defense.* Dr. Lee, chairman of the Committee on Civil Defense, reported on the meeting of the Emergency Council on Civil Defense which was held in Chicago November 9 and 10, 1951. (Full report in April JOURNAL.)



## 1952 Annual Session at Indianapolis

1. *Dates set by Executive Committee*—Tuesday, Wednesday and Thursday, October 28, 29 and 30, 1952.

2. *Report of Committee on Convention Arrangements.* Dr. J. Neill Garber, chairman, presented the following report:

"Much comment has arisen about various aspects of the 1951 convention of the Indiana State Medical Association in Indianapolis. I wish to discuss some of the suggestions which have been offered.

"Proposed changes in a convention program such as ours are frequently blocked by so-called 'tradition.' Traditions may be well-founded, but they also may be out-moded. We should be practical and bring our program up to date.

"The committee arranging the scientific program has, in the past, gone to great pains to provide excellent presentations by distinguished scientists from within and from outside the state. These men work hard to prepare their papers, and usually only a handful of people are in the audience. This embarrassing situation reflects poorly upon the entire state medical association. We should attempt a solution even though it means a radical departure from what has been done before.

"At present the whole convention day is jammed with scientific papers and meetings of various groups. A solution would be the drastic reduction of the scientific portion of the program to a single presentation in the morning and one in the afternoon for the second and third days of the convention. Meetings of the House of Delegates and other groups could be planned with this in mind so that all members would be free to attend the scientific program. The scientific program, thus reduced in volume, should include subjects by individuals or by panels of extraordinary distinction.

"We must clearly realize that it is difficult for doctors who practice in Marion county to spend much time at the convention when it is held in Indianapolis. We must also realize that many doctors who come from cities outside Marion county consider this a respite from their arduous duties at home and are not inclined to sit for hours listening to speakers regardless of their scientific stature or of their subjects.

"There is no way that these people can be driven to attend, but perhaps they can be attracted by an improvement in the quality of the program and by cutting the number of papers presented.

"Consider the fact that only five or six persons were in the Murat Temple audience at 9:00 a. m. on Tuesday, October 30, for the opening session of the 1951 convention. A few minutes later the distinguished guests, Drs. Lull and McVay, addressed an audience of only 40 or 50 persons, while hundreds of physicians were registered. It would seem that at least all members of the House of Delegates should be required to attend the opening ceremony. One of their meetings might be arranged so that these men would be in the auditorium at this time.

"Certain changes in the evening entertainment are proposed. Since the peak in registration is customarily reached on the second day of the convention and most of the members are still in town for that evening, it is suggested that the annual banquet be held then.

"A brief outline of the entertainment would be as follows:

*First evening*—Smoker and stag from 6 to 8 p. m., followed by entertainment for physicians and their wives.

*Second evening*—Annual banquet.

*Third day*—Scientific program, with close of the convention at 5:00 p. m. This evening could be used for fraternity and other group dinners as desired.

"The Committee on General Arrangements for the convention wishes to cooperate fully with the President, the Executive Committee, and the Council in planning the next convention of the association. Many contracts for speakers and for entertainment have to be made months ahead of the convention date. This necessarily requires an outline of the program early in the year as well.

"We respectfully request that there be a free exchange of ideas and suggestions between the office of the association and the Arrangements Committee. It is not unreasonable, we believe, to ask that proposed changes made in the program after it has once been outlined be made known to the Arrangements Committee."

3. *Budget.* Dr. Garber reported that the 1951 Convention Arrangements Committee had turned back to the state association treasury \$1,127.30 from the budget allowed by the Council.

On motion of Drs. Overpeck and Kennedy, Dr. Garber's request for a budget of \$6,000.00 for the 1952 convention was granted.

4. *Section or general meetings?* Drs. Clarke, Geider, Wright, Rang and Olson spoke in favor of going back to sectional programs.

Dr. Geider said the Seventh District is in favor of sectional meetings, and also the elimination of scientific meetings in the morning and conflicts in Council and House of Delegates' meetings with scientific meetings.

On motion of Drs. Howard and Catlett the Council ruled that no scientific sessions shall be held at the time the House of Delegates is in session.

By consent, the Council is to suggest to the Committee on Scientific Work that sectional meetings be held in 1952.

5. *Scientific exhibit.* By consent, the Council voted to have a scientific exhibit in 1952.

6. *Future meeting places.* Dr. Garber suggested that Cincinnati might be considered as a possible location for holding the annual convention.

## Membership Problems

## 1. 1951 membership report by districts:

County Society	No. M.D.'s in County	Members Dec. 31, 1951	Members Dec. 31, 1950	Loss—Gain	Eligible Non-Members	New Members	Removed and Retired	Deceased	Ineligible
<b>1st District</b>									
Posey	13	11	12	-1	--	--	2	1	--
Vanderburgh	211	185	184	1	11	8	18	3	3
Warrick	15	9	9	--	2	--	6	--	--
Spencer	10	7	8	-1	--	--	3	--	--
Perry	10	9	11	-2	1	--	--	--	--
Gibson	26	25	22	3	1	--	1	--	--
Pike	10	6	8	-2	3	--	1	1	--
Total	295	252	254	-2	18	8	31	5	3
<b>2nd District</b>									
Knox	46	40	45	-5	3	1	2	2	--
Daviess-									
Martin	32	26	24	2	4	2	2	1	--
*Sullivan	21	17	19	-2	2	1	3	1	--
Greene	22	21	21	--	--	--	2	--	--
Owen-Monroe	54	47	49	-2	6	1	1	2	--
Total	175	151	158	-7	15	5	8	8	--
<b>3d District</b>									
Lawrence	30	25	27	-2	1	--	4	1	--
Orange	13	8	14	-6	5	--	1	--	--
Crawford	5	5	4	1	--	--	2	--	--
*Washington	8	8	9	-1	--	--	2	1	--
Scott	6	4	4	--	--	--	2	--	--
Clark	29	21	24	-3	7	--	2	--	--
Floyd	36	34	32	2	--	3	1	1	--
*Harrison	10	8	7	1	1	1	--	1	--
Dubois	22	14	13	1	7	--	1	--	--
Total	159	127	134	-7	21	4	15	4	--
<b>4th District</b>									
Bartholomew									
Brown	32	24	26	-2	3	--	2	--	3
Jackson	21	18	17	1	1	--	2	--	--
*Decatur	17	14	14	--	1	--	2	--	--
*Jennings	10	9	8	1	1	1	1	--	--
Ripley	16	10	11	-1	3	--	1	2	--
Jefferson	26	20	20	--	4	--	3	--	--
Switzerland	5	5	4	1	--	--	--	--	--
*Dearborn-									
Ohio	18	16	16	--	--	--	1	1	1
Total	145	116	116	--	13	1	12	3	4
<b>5th District</b>									
Parke-									
Vermillion	29	25	25	--	2	--	2	1	--
Putnam	20	19	18	1	--	--	1	1	--
Vigo	127	116	121	-5	2	2	5	4	5
Clay	15	11	11	--	2	--	2	--	--
Total	191	171	175	-4	6	2	9	6	6
<b>6th District</b>									
Hancock	20	16	17	-1	4	1	--	--	--
*Henry	43	39	38	1	3	1	--	2	--
Wayne-Union	81	71	72	-1	3	--	9	1	3
Rush	15	13	12	1	--	--	2	--	--
*Fayette-									
Franklin	27	25	26	-1	--	--	3	2	--
Shelby	28	23	24	-1	1	--	5	1	--
Total	214	187	189	-2	11	2	19	6	3

County Society	No. M.D.'s in County	Members Dec. 31, 1951	Members Dec. 31, 1950	Loss—Gain	Eligible Non-Members	New Members	Removed and Retired	Deceased	Ineligible
<b>7th District</b>									
*Hendricks	22	20	17	3	--	1	1	--	2
Marion	984	874	861	13	71	60	71	13	19
Morgan	20	14	17	-3	3	1	2	1	--
Johnson	21	19	20	-1	1	--	1	--	1
Total	1047	927	915	12	75	62	75	14	22
<b>8th District</b>									
*Madison	101	91	92	-1	5	1	4	2	2
*Delaware-									
Blackford	116	96	109	-13	13	2	8	2	3
*Jay	22	16	19	-3	4	--	1	1	--
Randolph	26	23	23	--	2	1	--	1	--
Total	265	226	243	-17	24	4	13	6	5
<b>9th District</b>									
*Benton	13	8	11	-3	3	1	1	1	--
*Fountain-									
Warren	20	19	18	1	1	--	1	3	--
*Tippecanoe	110	95	97	-2	11	3	6	3	--
*Montgomery	34	29	28	1	2	1	4	1	--
*Clinton	32	24	28	-4	4	--	5	1	--
Tipton	16	13	13	--	--	--	3	1	--
Boone	26	20	23	-3	3	--	3	1	--
Hamilton	27	22	22	--	2	--	2	--	2
White	7	3	4	-1	1	--	1	--	2
Total	285	233	244	-11	27	5	26	11	4
<b>10th District</b>									
Lake	341	313	298	15	13	22	19	8	4
*Porter	25	24	24	--	--	--	1	3	--
*Jasper-									
Newton	23	18	18	--	2	1	6	1	--
Total	389	355	340	15	15	23	26	12	4
<b>11th District</b>									
Carroll	11	10	10	--	1	--	--	1	--
Cass	46	36	37	-1	1	2	6	3	2
Miami	23	19	19	--	2	--	--	--	2
*Wabash	27	24	20	4	1	--	3	--	--
*Huntington	26	24	24	--	1	--	--	--	1
*Howard	48	42	38	4	1	--	4	--	2
Grant	59	48	49	-1	9	2	4	2	--
Total	240	203	197	6	16	4	17	6	7
<b>12th District</b>									
LaGrange	8	8	8	--	--	--	--	1	--
Steuben	16	13	11	2	1	--	3	--	--
*Noble	26	25	26	-1	1	--	4	--	--
DeKalb	22	20	21	-1	2	--	2	--	--
Whitley	16	11	12	-1	2	--	--	3	1
Allen	227	201	196	5	13	9	9	5	6
Wells	33	29	30	-1	1	3	4	--	--
*Adams	20	18	19	-1	1	--	2	1	--
Total	368	325	323	2	21	12	24	10	7
<b>13th District</b>									
LaPorte	79	72	65	7	4	7	3	1	--
*St. Joseph	227	203	192	9	11	7	10	4	5
*Elkhart	97	89	83	6	1	5	8	4	--
Starke	8	7	6	1	1	1	--	--	--
Pulaski	7	7	7	--	--	--	--	1	--
Fulton	14	12	12	--	1	--	--	2	--
Marshall	24	16	23	-7	7	--	2	--	1
Kosciusko	19	12	15	-3	4	--	5	--	--
Total	475	418	403	15	29	20	28	12	6



County Society	No. M.D.'s in County	Members Dec. 31, 1951	Members Dec. 31, 1950	Loss—	Gain	Eligible Non-Members	New	Members	Removed and Retired	Deceased	Ineligible
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SUMMARY BY DISTRICT

1st District	295	252	254	-2	18	8	31	5	3		
2nd District	175	151	158	7	15	5	8	8	--		
3rd District	159	127	134	-7	21	4	15	4	--		
4th District	145	116	116	--	13	1	12	3	4		
5th District	191	171	175	-4	6	2	9	6	6		
6th District	214	187	189	-2	11	2	19	6	3		
7th District	1047	927	915	12	75	62	75	14	22		
8th District	265	226	243	-17	24	4	13	6	5		
9th District	285	233	244	-11	27	5	26	11	4		
10th District	389	355	340	15	15	23	26	12	4		
11th District	240	203	197	6	16	4	17	6	7		
12th District	368	325	323	2	21	12	24	10	7		
13th District	475	418	403	15	31	20	28	12	6		
Total	4248	3691	3691	--	292	152	303	103	71		

\* Physicians are listed in the counties in which they hold membership; not in the counties in which they reside.

45 physicians received membership gratis in 1951 because of military service.

210 physicians were senior members in 1951.

165 physicians paid dues of \$10.00 in 1951 as residents and internes.

38 physicians had their dues remitted by the Council in 1951.

2. *Remission of state dues.* On motion of Drs. Kennedy and Clarke, the Council voted to remit the 1952 dues of twenty-two members who had been certified by their respective county medical society secretaries.

New Business

1. *Indiana Inter-Professional Health Council.* On motion of Drs. Howard and Catlett, Dr. E. H. Clauser and Dr. William C. Reed were reappointed to serve as members of the Inter-Professional Health Council for 1952.

2. *Matters referred to Council by Executive Committee:*

a. *Rules governing resolutions to be presented to the House of Delegates.* Dr. Portteus, chairman, Executive Committee, said the committee felt that some mechanism should be set up whereby more time can be given, prior to the House of Delegates' meetings, to the resolutions to be presented, in order to avoid the passing of resolutions that have not been given proper consideration. Following discussion by Drs. Catlett, Cavins, Crimm, Clark and Mr. Stump, on motion of Drs. Crimm and Olson the Council ruled that resolutions which are to be introduced in the House of Delegates shall be sent to the headquarters office at least thirty days before the date of the meeting and the executive

secretary shall distribute copies of these resolutions to all members of the House of Delegates.

b. *Transfer of funds.* On motion of Drs. Olson and Catlett it was voted to invest \$10,000 of THE JOURNAL funds in U. S. Savings Bonds, Series G, and to place these bonds in the General Fund surplus.

3. *Nominations for Editorial Board.* Dr. Crimm nominated Dr. Harold D. Lynch, Evansville (pediatrics). Dr. Olson nominated Dr. Carl Culbertson, South Bend, (pathology). Additional nominations are to be made at the next Council meeting.

4. *Interim meeting of House of Delegates.* The following invitations were received: From Dr. Catlett, to meet in Fort Wayne; from Dr. Crimm, to meet in Evansville; from Dr. Geider, to meet in Indianapolis; from Dr. Olson, to meet in South Bend. The Council voted, 12 to 3, to hold the interim meeting of the House of Delegates in Indianapolis, on Sunday, April 27, 1952.

5. *Spring meeting of the Council.* The next meeting of the Council will be held on Saturday night, April 26, 1952.

6. *Agenda for Council meetings.* On motion of Drs. Garner and Howard enough copies of the agenda for each Council meeting are to be sent sufficiently in advance of the meeting date to allow time for study and discussion, to the councilors, for distribution to the presidents, secretaries and delegates of the county medical societies in their respective districts.

7. *Counting House of Delegates' ballots.* Dr. Olson suggested that the method of counting ballots in House of Delegates' elections should be changed to save time. The Council took no action as this change would not require an amendment to the Constitution and By-laws.

8. *Board of Directors, Mutual Medical Insurance, Inc.* On motion of Drs. Garner, Howard and Crimm, the Council approved the re-election of the following members on the Board of Directors of Mutual Medical Insurance, Inc., whose terms will expire in 1952: Drs. Wemple Dodds, Crawfordsville; C. J. Clark, Indianapolis; G. O. Larson, LaPorte; Charles Overpeck, Greensburg; A. F. Weyerbacher, Indianapolis, and E. S. Jones, Hammond.

On motion of Drs. Catlett and Garner, a rising vote of thanks was given to Dr. Kennedy for his excellent work and service as chairman of the Council since September 29, 1949.

A rising vote of thanks also was accorded Dr. Clauser, chairman of the Screening Committee.

There being no further business, the meeting was adjourned.

## EXECUTIVE COMMITTEE

January 12, 1952

Roll call showed the following present: W. L. Porteus, M.D., chairman; C. J. Clark, M.D.; J. William Wright, Sr., M.D.; Paul D. Crimm, M.D.; W. U. Kennedy, M.D.; Roy V. Myers, M.D.

Albert Stump, attorney, and James A. Waggener, executive secretary.

## Membership Report

Number of members, January 10, 1952---- 454\*  
 Number of members, January 10, 1951---- 454  
 Number of members, December 31, 1951----3682

\*Includes 7 in military service (gratis)

21—\$10.00 members (residents and interns)

26—senior members

3—members, dues remitted by Council

Number who have paid 1952 AMA dues--- 367

Number who have paid 1951 AMA dues---2906

Number who have paid 1950 AMA dues---2890

Following review of the membership report the secretary reported on the method used by the headquarters office in notifying counties of delinquent members, a procedure which had been completed prior to the request of the committee.

*Payment of delinquent dues.* The question of Indiana requiring a member to pay delinquent dues before acceptance as a new member or for reinstatement was discussed and the secretary was instructed to get the A.M.A.'s stand on this matter.

## Treasurer's Office

*Auditor's report* for 1951 was presented to the committee.

*Investment of surplus JOURNAL funds.* By consent it was voted that \$10,000 of THE JOURNAL funds be invested in U. S. Savings bonds, series G, and that these bonds be placed in the General Fund surplus.

## Legislative Matters

*National*—The secretary reported on the action of the A.M.A. House of Delegates adopting the resolution submitted by Indiana dealing with the deferment of chiropractic students under the Selective Service Act.

*Local*—The secretary reported on the progress being made with the Illinois Board in attempting to arrange reciprocity agreements for Indiana physicians.

Statements of receipts and expenditures and report on the Budget for November and December for the association and THE JOURNAL were approved.

## Organization Matters

*Payment of A.M.A. delegates' expenses.* By consent the following policy was established for payment of traveling expenses of A.M.A. delegates:

Round trip fare, based on train fare, plus \$10.00 per day for meeting days and travel time, travel time to be based on the amount of time required to travel by train.

*Membership in Indiana Taxpayers Association.* A \$25.00 membership in the Indiana Taxpayers Association for 1952 was approved on motion of Drs. Wright and Crimm.

Letter regarding a matter of ethics, and reply by the association's attorney were reviewed by the committee, and by consent it was agreed that this reply should stand as being that from the association.

An additional subscription to The Washington Report on the Medical Sciences for the chairman of the Legislative Committee was approved upon motion of Drs. Crimm and Wright.

*Welfare proposal.* The secretary reported on the recent meetings with directors of County Departments of Public Welfare and their opinion that the medical plan should not be changed from the one now in existence at the various county levels.

*"Medicine of the Year."* Request of the Tennessee State Medical Association for cooperation of the association in purchasing a quantity of books, "Medicine of the Year," for resale to members of the association was not approved.

## The Journal

*Report on advertising:*

Total advertising in 1951.....	\$27,897.04
Total advertising in 1950.....	27,080.81

Gain in 1951.....	\$ 816.23
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## Future Meetings

February 10, 1952—Conference on Medical Service, Chicago.

February 10-12, 1952—Annual Congress on Medical Education and Licensure, Chicago.

On motion of Drs. Wright and Clark, the executive secretary and the president are to attend the two above meetings.

There being no further business, the committee adjourned to meet again on February 17, 1952, at the Columbia Club, Indianapolis.

## SPECIAL MEETING OF THE EXECUTIVE COMMITTEE—JANUARY 13, 1952

Immediately following the close of the Council meeting, which was held on Sunday, January 13, 1952, the Executive Committee met to elect a chairman. Dr. C. J. Clark was elected chairman for 1952.



## COMMITTEE ON PUBLICITY

January 4, 1952

Present: D. S. Megenhardt, M.D., chairman; J. O. Ritchey, M.D.; Homer G. Hamer, M.D., and Jas. A. Waggener, executive secretary.

The following "Hints on Health" columns were approved:

Week of February 3, 1952—"That Cold"

Week of February 10, 1952—"Blood Circulation"

Week of February 17, 1952—"Ingrown Toenails"

Week of February 24, 1952—"Dust"

The committee selected the new radio series entitled "Gold Medal Doctors" to replace the present series upon expiration.

The request for a speaker for the Grant County Auxiliary is to be filled with a member of the association's Committee on Legislation at a meeting of physicians and wives. If it is a public meeting, it was suggested that a speaker from the speakers bureau be supplied.

## COUNTY MEDICAL SOCIETY OFFICERS

## BARTHOLOMEW-BROWN COUNTY MEDICAL SOCIETY

President, T. D. Carpenter, Columbus

Vice-President, R. B. Hart, Columbus

Secretary-Treasurer, David L. Adler, Columbus

## CASS COUNTY MEDICAL SOCIETY

President, Foss Schenck, Logansport

Vice-President, W. W. Holmes, Logansport

Secretary-Treasurer, Bryce Fitzgerald, Logansport

## CLARK COUNTY MEDICAL SOCIETY

President, Eli Goodman, Charlestown

Vice-President, Lee Dare, Jeffersonville

Secretary-Treasurer, William R. Greene, Henryville

## CLINTON COUNTY MEDICAL SOCIETY

President, T. A. Dykhuizen, Frankfort

Vice-President, Paul T. Van Kirk, Frankfort

Secretary-Treasurer, C. D. Holmes, Frankfort

## DAVISS-MARTIN COUNTY MEDICAL SOCIETY

President, John J. Farris, Washington

Vice-President, William C. Schafer, Washington

Secretary-Treasurer, H. R. Schroeder, Washington

## ELKHART COUNTY MEDICAL SOCIETY

President, H. C. Amstutz, Goshen

Vice-President, V. K. Pancost, Elkhart

Secretary-Treasurer, George R. Bloom, Elkhart

## FULTON COUNTY MEDICAL SOCIETY

President, John Glackman, Rochester

Vice-President, E. V. Herendeen, Rochester

Secretary-Treasurer, L. E. Kelsey, Kewanna

## GIBSON COUNTY MEDICAL SOCIETY

President, E. V. Marchand, Haubstadt

Vice-President, M. A. Turner, Oakland City

Secretary-Treasurer, R. E. Weitzel, Princeton

## GREENE COUNTY MEDICAL SOCIETY

President, R. E. Moses, Worthington

Vice-President, Asa Fender, Worthington

Secretary-Treasurer, J. A. Graf, Bloomfield

## HANCOCK COUNTY MEDICAL SOCIETY

President, R. E. Kinneman, Greenfield

Vice-President, Harold Manifold, Fortville

Secretary-Treasurer, Wayne H. Endicott, Greenfield

## HENDRICKS COUNTY MEDICAL SOCIETY

President, Elmer Koch, Danville

Vice-President, Lloyd Foltz, Brownsburg

Secretary-Treasurer, M. O. Scamahorn, Pittsboro

## HENRY COUNTY MEDICAL SOCIETY

President, John E. Fisher, New Castle

Vice-President, Arthur B. Burnett, New Castle

Secretary-Treasurer, Ray T. Foster, New Castle

## HOWARD COUNTY MEDICAL SOCIETY

President, G. B. Bowers, Kokomo

1st Vice-President, Guy Morford, Kokomo

2nd Vice-President, Robert W. Phares, Kokomo

Secretary-Treasurer, Thomas M. Conley, Kokomo

## JACKSON COUNTY MEDICAL SOCIETY

President, John W. Ripley, Seymour

Vice-President, C. A. Wiethoff, Seymour

Secretary-Treasurer, G. H. Kamman, Seymour

## JEFFERSON COUNTY MEDICAL SOCIETY

President, W. E. Childs, Madison

Vice-President, O. A. Turner, Madison

Secretary-Treasurer, Marcella S. Modisett, Madison

## JENNINGS COUNTY MEDICAL SOCIETY

President, W. H. Stemm, North Vernon

Vice-President, D. W. Matthews, North Vernon

Secretary-Treasurer, John H. Green, North Vernon

## KOSCIUSKO COUNTY MEDICAL SOCIETY

President, George Schlemmer, Warsaw

Vice-President, G. N. Herring, Pierceton

Secretary-Treasurer, Ryland Roesch, Warsaw

## LAKE COUNTY MEDICAL SOCIETY

President, M. B. Gevirtz, Hammond

President-Elect, John E. Komoroske, East Chicago

Secretary-Treasurer, David B. Templin, Gary

## LAPORTE COUNTY MEDICAL SOCIETY

President, M. G. Meyer, Michigan City

Vice-President, V. F. Kling, Michigan City

Secretary-Treasurer, J. C. Richter, LaPorte

## MADISON COUNTY MEDICAL SOCIETY

President, J. L. Larmore, Anderson

Vice-President, William Van Ness, Summitville

Secretary-Treasurer, W. E. Fischer, Anderson

**MIAMI COUNTY MEDICAL SOCIETY**

President, Owen Johnson, Peru  
 Vice-President, R. E. Barnett, Peru  
 Secretary-Treasurer, C. R. Herd, Peru

**MONTGOMERY COUNTY MEDICAL SOCIETY**

President, Wemple Dodds, Crawfordsville  
 Vice-President, John Humphreys, Crawfordsville  
 Secretary-Treasurer, Jess E. Burks, Crawfordsville

**POSEY COUNTY MEDICAL SOCIETY**

President, A. L. Woods, Poseyville  
 Vice-President, J. W. Herr, Mt. Vernon  
 Secretary-Treasurer, L. John Vogel, Mt. Vernon

**PUTNAM COUNTY MEDICAL SOCIETY**

President, George T. Tennis, Greencastle  
 Vice-President, Richard L. Veach, Bainbridge  
 Secretary-Treasurer, Anne S. Nichols, Greencastle

**ST. JOSEPH COUNTY MEDICAL SOCIETY**

President, L. G. Ericksen, South Bend  
 Vice-President, M. E. Whitlock, Mishawaka  
 Secretary-Treasurer, M. I. Hewitt, South Bend

**SCOTT COUNTY MEDICAL SOCIETY**

President, C. R. Bogardus, Austin  
 Vice-President, Marvin L. McClain, Scottsburg  
 Secretary-Treasurer, Floyd S. Napper, Scottsburg

**SHELBY COUNTY MEDICAL SOCIETY**

President, R. C. Miller, Shelbyville  
 Vice-President, R. D. Spindler, Shelbyville  
 Secretary-Treasurer, W. L. Dalton, Shelbyville

**STARKE COUNTY MEDICAL SOCIETY**

President, J. F. DeNaut, Knox  
 Vice-President, J. R. Matthews, North Judson  
 Secretary-Treasurer, G. B. Ingwell, Knox

**STEBEN COUNTY MEDICAL SOCIETY**

President, J. A. Alford, Hamilton  
 Vice-President, D. W. Creel, Angola  
 Secretary-Treasurer, D. G. Mason, Angola

**VANDERBURGH COUNTY MEDICAL SOCIETY**

President, R. L. Kleindorfer, Evansville  
 President-Elect, E. L. Fitzsimmons, Evansville  
 Treasurer, Russell J. Rossow, Evansville

**VIGO COUNTY MEDICAL SOCIETY**

President, Norman Silverman, Terre Haute  
 Vice-President, W. W. Kriebel, Terre Haute  
 Secretary-Treasurer, A. M. Mitchell, Terre Haute

**WABASH COUNTY MEDICAL SOCIETY**

President, Charles E. Cook, North Manchester  
 Vice-President, O. G. Brubaker, North Manchester  
 Secretary-Treasurer, A. J. Steffen, Wabash

**WASHINGTON COUNTY MEDICAL SOCIETY**

President, Irvin E. Huckleberry, Salem  
 Secretary-Treasurer, A. R. Episcopo, Salem

**WHITLEY COUNTY MEDICAL SOCIETY**

President, Jules Heritier, Columbia City  
 Vice-President, E. A. Hershey, Churubusco  
 Secretary-Treasurer, Paul E. Kratz, Columbia City

**LOCAL SOCIETY REPORTS**

Cass County Medical Society members met at Logansport on January 8. Twenty-three members were present. In addition to participating in the telephone seminar, Mr. Robert Price spoke on the proposed fluoridation of water.

Another meeting was held at the Memorial Hospital in Logansport on February 6, when thirty-one members and guests were present. Following the telephone seminar, Mr. Paul Eagan, of Blue Cross, spoke.

Clark County Medical Society members met at the Clark County Hospital in Jeffersonville on January 19. This was a business meeting, and twenty-one members were present.

Clay County Medical Society met at the Log Cabin Restaurant in Brazil on January 15. Ten members were present.

Clinton County Medical Society members met in Frankfort on December 4, for election of officers. Seventeen members were present.

Another meeting was held on January 15, with sixteen members present. Special and standing committees were appointed.

Fayette-Franklin County Medical Society members met at the Connersville Country Club on January 8. Twelve members were present to hear Dr. W. N. Wishard, Jr., of Indianapolis, speak on "Tumors of the Genito-Urinary System."

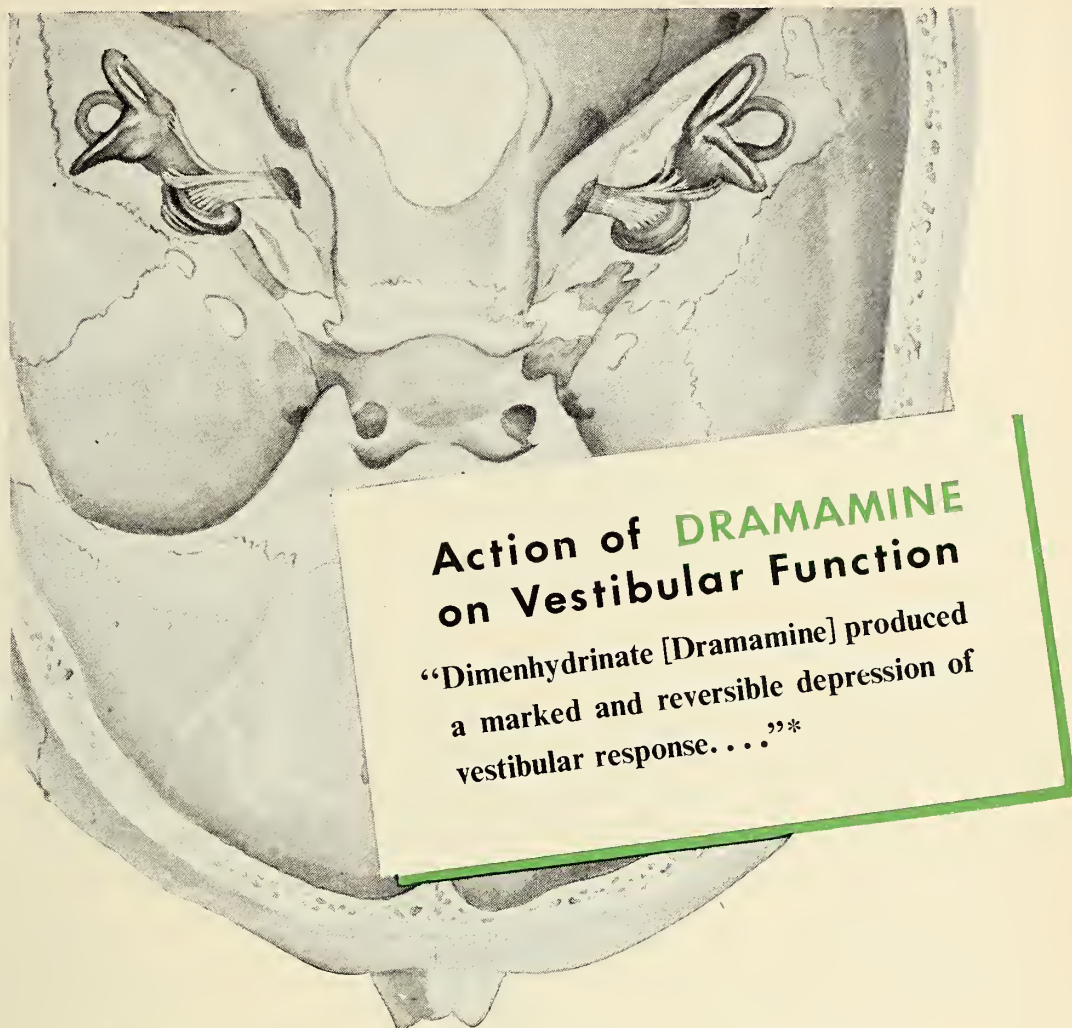
Gibson County Medical Society members met in Oakland City on January 14. Dr. George Willison, of Evansville, spoke on "Acute Medical Emergencies of the Abdomen." Fifteen members were present.

Hancock County Medical Society met at Hancock County Memorial Hospital on January 7. This was a business meeting and eighteen members were present.

Henry County Medical Society members met at the Henry County Hospital in New Castle on January 17. Seventeen members were present for the appointment of committees for the year.

Howard County Medical Society members met at the Frances Hotel in Kokomo on January 4. Thirty-six members and guests were present to hear Dr. Lall Montgomery, of Muncie, speak on "Inter-relationship of Gallbladder Disease and Pancreatitis."





In a study of the action of Dramamine on vestibular function, Gutner and his associates found that Dramamine “significantly delayed the onset of nystagmus, shortened the duration of nystagmus and increased the milli-ampere necessary to effect tilting.”

The great effectiveness of Dramamine in motion sickness, they state, “. . . is probably related primarily to its ability to depress vestibular function. . . .”

## **DRAMAMINE®**

**BRAND OF DIMENHYDRINATE**

—for prevention and treatment of motion sickness—

Now available in these dosage forms: { Tablets — 50 mg.  
Liquid — 12 mg. per 4 cc.  
Average dose — 50 mg.



\*Gutner, L. B.; Gould, W. J., and Batterman, R. D.: Action of Dimenhydrinate (Dramamine) and Other Drugs on Vestibular Function, Arch. Otolaryng. 53:308 (March) 1951.

RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

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Jefferson County Medical Society met at the Fiesta Cafe in Madison on January 9. Dr. Harvey Sigmond, of Indianapolis, was the guest speaker. His subject was "Colles Fracture." Ten members were present.

---

LaPorte County Medical Society members met at the Peacock Fountain Inn at LaPorte on January 17. Fifty members and guests were present. Mr. L. E. Converse, of Blue Shield, spoke on "Public Relations."

---

Madison County Medical Society members met at General Motors in Anderson on December 17. Forty-two members were present. Annual election of officers was held, and Mr. Earl Bramblett spoke on "Labor Demands in Medical Insurance Field."

---

Montgomery County Medical Society held a meeting at Culver Hospital in Crawfordsville on December 20. Nineteen members were present to hear a recording on "The Newer Aspects of the Diagnosis and Treatment of Tuberculosis."

A business meeting was held on January 17, when twenty-seven members were in attendance.

---

Parke-Vermillion County Medical Society met at Vermillion County Hospital at Clinton on January 16. Twelve members were present to hear Dr. Don Mattox, of Terre Haute, speak on "Carcinoma of the Bowel."

---

Perry County Medical Society members met at the Perry County Nursing Center at Cannelton on January 1. This was a business meeting and five members were present.

At another meeting, on February 5, nine members were present to hear a recording on "Non-malignant Diseases of the Colon."

---

Putnam County Medical Society members met for election of officers at DePauw Union Building, in Greencastle, on December 14. Sixteen members were present. A film was shown on "Early Diagnosis of Cancer of the Breast."

At another meeting, on January 11, Dr. Lyman T. Meiks, of Indianapolis, spoke on "Infant Feeding." Eighteen members were in attendance.

---

Ripley County Medical Society members held a dinner and business meeting at the Sherman House in Batesville on January 22. Six members and one guest were present.

---

Shelby County Medical Society members met in Shelbyville on December 19 for election of officers. They also heard a recording on "Surgical Emergencies."

---

Steuben County Medical Society members held a business meeting on January 31 at the Cameron Hospital in Angola. Seven members were present.

---

Tippecanoe County Medical Society members met at the Lincoln Lodge in Lafayette on January 8. Fifty members were present to hear Dr. William Gambill, of Indianapolis, speak on "Cirrhosis of the Liver."

---

Vanderburgh County Medical Society members met on January 8 at the McCurdy Hotel in Evansville. More than one hundred members were present to hear Dr. John J. Brosnan, of the Stritch School of Medicine of Loyola University, Chicago, speak on "Differential Diagnosis of Chest Lesions." New officers for 1952 were installed at this meeting.

---

Wabash County Medical Society members met at the Sheller Hotel in North Manchester, on January 16. Eleven members were present to hear Dr. George R. Horton, of Fort Wayne, speak on "Prostatism."

---

Wells County Medical Society members met at the Caylor-Nickel Clinic on January 21. Fifteen members were present to hear Dr. S. Bruce Kephart give a review of papers at medical meetings.

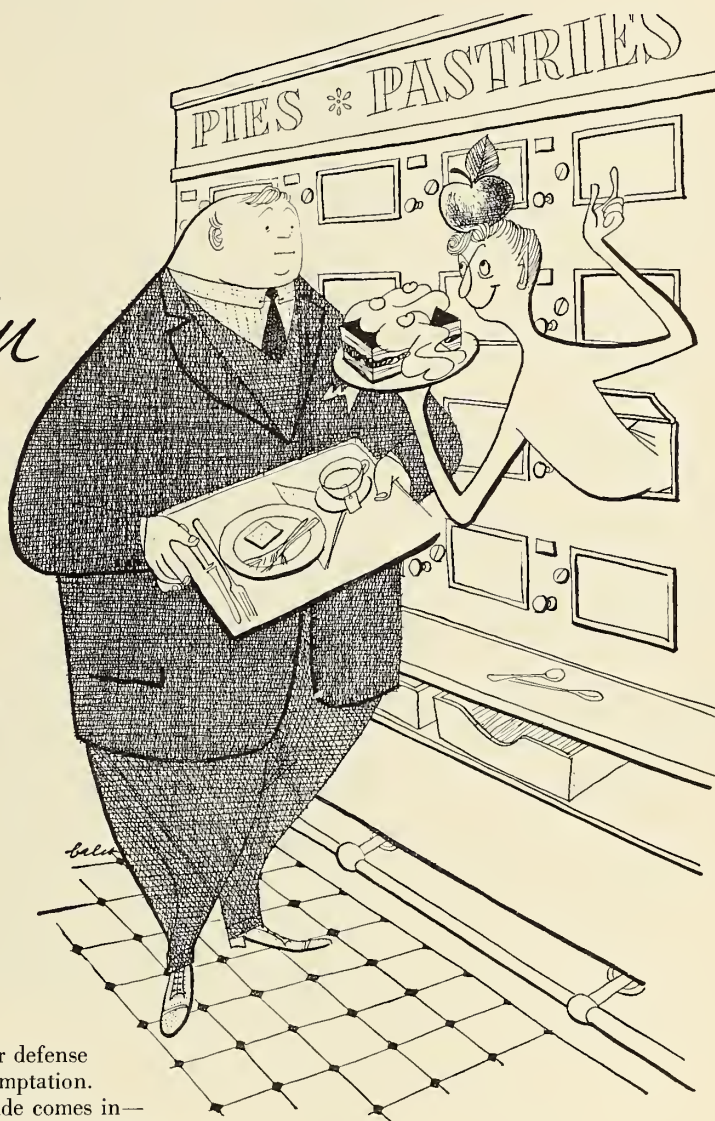
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Whitley County Medical Society members met at the Whitley County Memorial Hospital in Columbia City on December 11. Dr. F. T. Thompson, of Columbia City, spoke on "Arterial Hypertension." Nine members were present.

Another meeting was held on January 15, when fourteen members were present. The guest speakers were Dr. T. G. Hamilton, of Columbia City, and Dr. K. R. Schlademan, of Fort Wayne. Doctor Hamilton spoke on "Chondroblastoma," and Doctor Schlademan presented a case report with a review of the literature.



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DESOXYN is equally effective as a valuable adjunct in depressive states associated with the menopause, prolonged illness and convalescence as well as in the treatment of narcolepsy and for adjunctive therapy in alcoholism. All pharmacies have DESOXYN in 2.5-mg. and 5-mg. tablets, in elixir form and in 1-cc. ampoules.

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*to the*  
**Indiana State Medical Association**

**President—Mrs. F. M. Fargher, Michigan City.**

**President-Elect—Mrs. Hubert T. Goodman, Terre Haute.**

**Corresponding Secretary—Mrs. Victor F. Kling, Michigan City.**

**Recording Secretary—Mrs. Elmer Singer, Fort Wayne.**

**Treasurer—Mrs. Robert Bolin, Elkhart.**

**Publicity—Mrs. F. M. Gastineau, Indianapolis.**

Dr. John Cline, president of the A.M.A., will be the speaker at the dinner at the eighth annual House of Delegates meeting of the Woman's Auxiliary to the Indiana State Medical Association. All Auxiliary members are invited to attend and we hope will avail themselves of the opportunity of hearing such a distinguished speaker.

The Allen County Medical Auxiliary will act as hostesses for the meeting, to be held April 24 and 25 at the Van Orman Hotel, Fort Wayne.

**Calendar of Events:**

**Thursday, April 24.**

Registration 10:30 a.m.-5:30 p.m.—Mezzanine.  
Badges, meal tickets, programs.

Board Meeting 12:30—The Chatterbox.  
General Session 2:00-4:30 p.m.—The Chatterbox.

Cocktail and Punch Hour 6:00-7:00 p.m.—Mezzanine.

Dinner 7:00 p.m.—Ballroom.

**Friday, April 25.**

Breakfast 8:45 a.m.—Ballroom.

General Session, Continued, 10:00 a.m.—The Chatterbox.

Luncheon 1:00 p.m.—Ballroom.

We recommend that each Auxiliary make hotel reservations at once for President, President-elect and your delegates—one for each 25 members or fraction thereof—as our Constitution provides. These will be given preference at the hotel until April 1, after which reservations for others will be taken.

**You Are Invited to the  
FIFTH ANNUAL  
SYMPOSIUM ON MALIGNANCY**

at the

**Indiana University School of Medicine  
WEDNESDAY, APRIL 2, 1952**

**Subject: CARCINOMA of the BREAST**

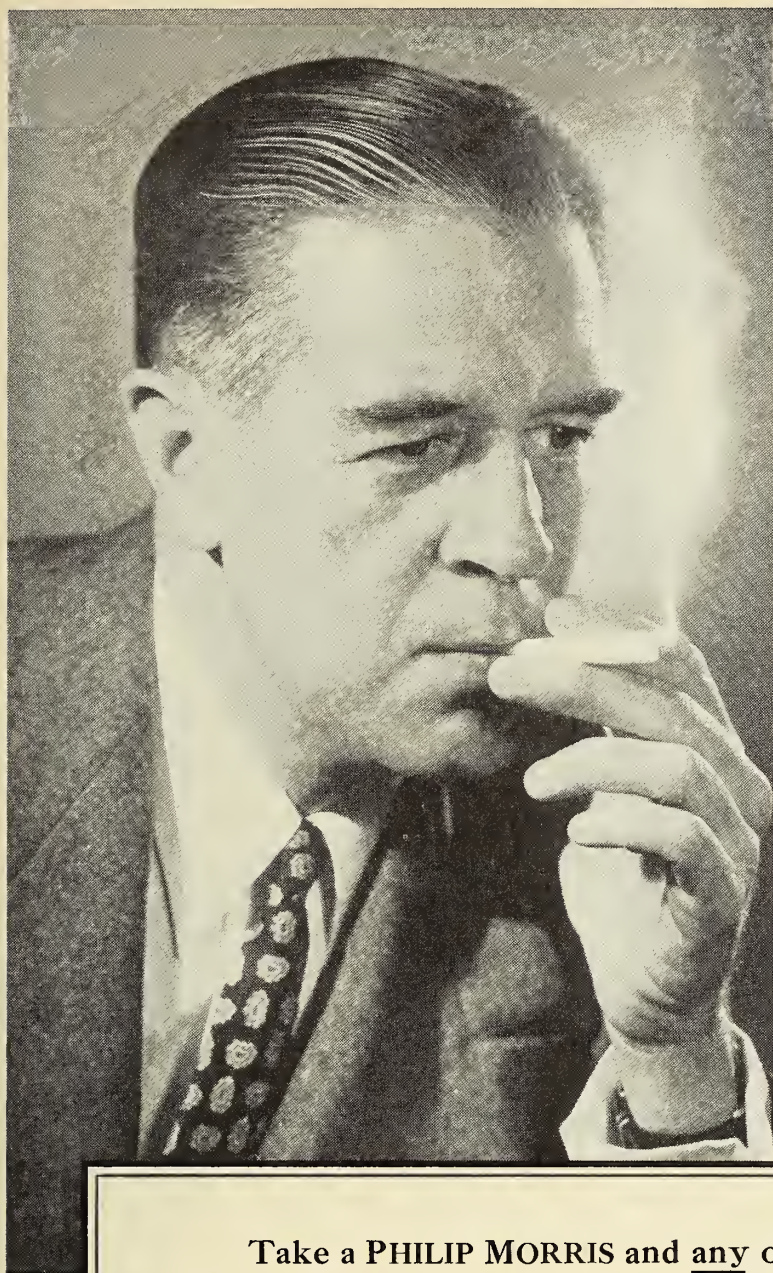
Speakers: L. V. Ackerman, M.D., Washington University School of Medicine; Shields Warren, M.D., Harvard Medical School; M. M. Copeland, M.D., Georgetown University Medical Center; E. M. Bricker, M.D., Washington University School of Medicine; C. D. Haagensen, M.D., Columbia University College of Physicians and Surgeons; G. W. Taylor, M.D., Harvard Medical School; U. V. Portmann, M.D., Cleveland Clinic; I. T. Nathanson, M.D., Harvard Medical School.

*presented by the*

**I. U. School of Medicine and the Indiana Cancer Society**

The Symposium Speakers will present the Postgraduate Telephone Program Tuesday evening, April 1. Physicians are invited to mail questions for discussion by the panel in care of: Cancer Committee, Indiana University Medical Center, Indianapolis 7, Indiana.





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## Books

Books received are acknowledged in this column, and such acknowledgment must be regarded as a sufficient return for the courtesy of the sender. Selections will be made for more extensive review in the interests of our readers and as space permits. Books listed in this department are not available for lending. Any information concerning them will be supplied on request.

**THE CHANGING YEARS.** By Madeline Gray, an experienced writer, who assembled the results of four years reading, lectures, interviews and correspondence with doctors, on "what to do about the menopause." Price \$2.75. Doubleday & Company, Inc., Garden City, N. Y., 1952. Copyright by author.

The author of this book, Madeline Gray, is a very clever popular writer. Before writing the book she secured a vast amount of authentic medical information from reliable sources which she freely quotes.

The problems, fears and worries of the middle-aged woman are considered in a manner which clarifies many obscure and troublesome ideas about the menopause.

Four chapters of the book are devoted to female physiology and endocrinology. All of this material is from authentic sources and told in such a manner that a lay person can easily grasp it. That is no minor literary achievement. While insignificant disturbances are minimized, such serious symptoms as abnormal bleeding are accorded proper importance. The author even discusses the so-called "male change" and rightly points out its nonexistence.

In the chapter devoted to what the doctor can do for women in the changing years it is pointed out that only about 25 percent of women really need any medical treatment. And when hormone therapy, which is specific, is needed the medication can be taken orally and there is no need for "shots." All through the book the author advises women during middle and later life to keep busy at some remunerative and productive enterprise. Throughout the text the woman reader is advised to frequently consult a competent physician.

Love and sex life of middle-aged and older women is discussed at considerable length, and the usual sex problems are considered. The subject is handled by the author in a masterful fashion and the advice given is unusually sound.

The material of this book is presented in a very attractive manner. Much is addressed to the reader in the second person, which makes it very readable. Many short narratives about real people are used to bring out important points. The paragraphing and word selection are excellent. At the end of the book the author has listed the doctors she has interviewed and the medical books that she has used for background and special information.

This book can be unreservedly recommended to women patients, and can be read with profit by physicians.

D.A.B.

**HANDBOOK OF PEDIATRIC MEDICAL EMERGENCIES.** By Adolph G. DeSanctis, M.D., and Charles Varga, M.D., both of New York University-Bellevue Medical Center. 284 pages, with 51 illustrations. Price \$5.00. The C. V. Mosby Company, St. Louis, 1951.

The outline form of presentation, excellent illustrations, and compact reference tables make this handbook a most useful tool to have on the office desk or automobile seat of the physician who must occasionally give emergency treatment to children. It is designed to guide the physician in what to do immediately in various situations when "on-the-spot" therapy must be administered correctly, safely and effectively.

The first section gives special reference to such conditions, among which are acute cardiac failure, pericardial effusion; acute toxic diarrhea, with treatment to maintain the body fluids, electrolytes, and nutrition; vomiting, acute surgical abdomen, foreign bodies; anuria; convulsions; head injuries, coma; diabetes; croup, laryngotracheobronchitis, asthma; drowning; poisoning; bites; burns; transfusion reactions; shock, etc. A brief clinical discussion helps the physician to know that the diagnosis is correct, but this discussion is minimal; the text is almost completely on therapy.

Another section of this book deals with the proper techniques of performing such pediatric procedures as restraint, vein puncture, cannulization for continuous intravenous medication, lavage, lumbar puncture, subdural tap, tracheotomy, areosol, and oxygen therapy.

An appendix contains tables listing the commercial sources of poisons, giving the trade names of substances, the foreign ingredient, and reference page in the text for the discussion as to therapy. Another excellent table is that of poisons generally found in household articles. A table lists the normal physical and chemical constants—blood values of importance in evaluating states of dehydration, electrolyte disturbance, acid-base balance, etc., and common variations in determinations. Conditions increasing or decreasing the normal values are indicated.

The text is completely indexed, and each chapter has references to the literature.

T.M.C.



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## THE DIAGNOSIS AND CONTROL OF CANCER OF THE COLON AND RECTUM\*

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THE diagnosis and control of cancer is one of the problems foremost in the minds of all physicians today and has attracted a great deal of attention in the lay press. Patients are being urged to consult their family physicians upon the slightest suggestion of anything that might conceivably be symptomatic of an early cancer and they are reporting much more promptly than has been true in the past. As a result, as physicians, we assume a serious responsibility. We must be on the alert for the earliest possible evidence of cancer and must make certain that all indicated diagnostic procedures available have been resorted to before saying whether or not a cancer or a potentially cancerous lesion is present.

Whitehead<sup>1</sup> reports statistics compiled by Dublin, of the Metropolitan Insurance Company, showing that 17 percent of all deaths caused by cancer are traceable to cancer of the colon and rectum. Weber<sup>2</sup> cites statistical studies by Dixon showing a five year survival rate of just under 50 percent in a large series of cases; furthermore, he states that in a group of patients without manifest metastatic lesions at the time of operation, the five year survival rate was 62 percent. Rankin and Johnson<sup>1</sup> report a five year survival of 52.6 percent in 453 patients operated upon for cancer of the colon, with approximately 25 percent improvement in survival after five years in those with no demonstrable metastases at the time of operation.

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\* Presented at the annual session of the Indiana State Medical Association, in Indianapolis, on October 30, 1951

It is obvious from the above that much is and can be done in the control of cancer of the colon

and rectum, but it is equally evident that much still needs to be done. Earlier diagnosis and definitive therapy can greatly improve our five year results.

#### ESSENTIALS IN DIAGNOSIS

We all recognize that the patient must consult his or her physician promptly should symptoms of possible disease develop, if an early diagnosis is to be made. Likewise, the physician must be on the alert and not ignore what seem to be minor complaints and, if therapeutic results are to improve, must ever keep foremost in mind the possibility of cancer. Any possible suggestion of a developing cancer demands the most careful and detailed investigation. This must be initiated by the patient's own physician who, when he has exhausted all indicated diagnostic procedures available within his own organization, is duty bound, when indicated, to recommend and urge consultation and that any other recommended diagnostic procedures be carried out.

The physician first seeing the patient is primarily responsible for a very detailed history. This history may not be available to all consultants, however, and it behooves each to be familiar with the history, and in most instances it is advisable to secure a brief but essential one from the patient at the time of examination.

Weber<sup>2</sup> states as follows: "Certainly it is imperative to submit any patient to a most thorough intestinal investigation who has one or more of the following clinical symptoms and signs. (1) Chronic loss of blood, manifest most frequently by the appearance of blood in the stool and less frequently by secondary anemia; (2) significant and persistent alteration in the functional activity of the intestine; (3) abdominal pain of a colicky, crampy type, often intermittent; (4) abdominal tumor. The patient with early or even late intestinal cancer may exhibit one, several, all or—of equal importance—none of these symptoms and signs."

Bell and Douglas<sup>1</sup> list symptoms and signs in what they consider their order of importance as follows: (1) Recent change in bowel habits; (2) abdominal discomfort or pain indicating traction on a pedunculated mass or interference with passage of material through the bowel; (3) rectal bleeding, its character, duration, and amount; (4) indigestion; and (5) evidence of progressive anemia.

A complete physical examination is always essential and the primary responsibility for this rests with the physician first consulted by the patient. A digital rectal examination should always be a part of this initial examination. In this connection Weber<sup>2</sup> says: "It has been said that 50 percent of malignant neoplasms occurring in the rectum are discoverable with digital examination of the rectum. I assume, I think justly, that the lesions thus discovered are larger lesions. Certainly a great majority of the small lesions will escape detection if the rectal examination is considered complete when a digital examination has been done."

The next essential in diagnosis and one that as nearly as possible should be routine is the proctosigmoidoscopic examination. Unfortunately it still is not as widely used as should be the case. Weber<sup>2</sup> states: "It has been established that 60 percent of malignant and potentially malignant lesions of the large intestine occur in the rectum and in that portion of the sigmoid colon which is within reach of the 25 cm. proctosigmoidoscope." He continues: "No proctosigmoidoscope examiner who wishes to be called competent will refuse to accept the responsibility for the diagnosis of any neoplastic lesion in the rectum and lower portion of the sigmoid colon which has attained the macroscopic size of 5 mm. or more."

Those experienced in the diagnosis of lesions of the rectum and of the portion of the sigmoid that can be examined with the sigmoidoscope readily agree that in this region the proctosigmoidoscopic examination is the most reliable single diagnostic measure. It too has limitations, however, and diagnostic accuracy depends greatly upon the skill, experience and knowledge of the examiner. Irritability, sharp angulation and failure to cleanse satisfactorily the region under investigation may make difficult or impossible an adequate examination. In such instances the x-ray method may prove the more reliable. In a properly done roentgen examination with the opaque enema, relatively few carcinomas of appreciable size in the rectum and lower sigmoid will be overlooked but we agree with Weber that the primary responsibility for diagnosis must rest on the shoulders of the one doing the proctosigmoidoscopic examination.

The x-ray examination of the colon is the most accurate diagnostic method available above the region that can be examined by the sigmoido-



scope although it has its limitations. Lesions unquestionably at one time are so small that they cannot be detected by roentgenologic examination or any other known diagnostic procedure short of microscopic sections and there are many other well known potential sources of error in diagnosis.

In the diagnosis of cancer of the colon by x-ray the primary means of investigation is the ordinary type of barium enema. It is essential that this be preceded by thorough cleansing of the bowel, for fecal masses may exactly simulate polypoid lesions and may closely resemble invading carcinomas. The examination itself requires careful detailed fluoroscopic observation during filling, and films showing all parts of the bowel after filling and after evacuation in indicated projections.

The so-called double contrast type of examination of the large bowel has a very important place in the detection of polyps and at times is useful in the demonstration of frank cancers when findings otherwise are inconclusive. A major problem in the double contrast examination is thorough cleansing of the bowel for it may be most difficult to eliminate all waste products even when the patient is on a residue-free diet and catharsis has been thorough. A satisfactory examination usually can be accomplished but my associates and I have about reached the conclusion that it would be wise to do examinations on two consecutive days, thorough cleansing of the bowel with castor oil preceding each, the patient being on a residue-free diet twelve hours before and during the period of observation. It is generally known that masses of fecal material can be differentiated with certainty from polyps only by re-examination and this so often is indicated that it might well be routine.

We have used various preparations for double contrast examinations but continue to consider the one known as I X barium the most satisfactory. Approximately 300 cc., 10 fluid ounces by measure of the powdered contrast material being suspended in 600 cc., 20 fluid ounces by measure, of warm tap water. When thoroughly mixed the preparation has the consistency of relatively heavy cream, as has long been recommended by Weber.

When administering the enema the injection is stopped just as the head of the column passes

proximal to the splenic flexure and the enema tip is removed. The patient is rotated from side to side and from the supine to the prone. He then is urged to empty the lower bowel as rapidly as possible and to return promptly for the injection of air. All parts of the bowel are distended to a point where only slight discomfort is experienced by the patient, after which stereoscopic films are made in the postero-anterior, the right postero-anterior oblique and antero-posterior projections, the postero-anterior and antero-posterior films being 14 x 17 inches in size and the obliques 10 x 12. These films are processed and then viewed while the patient is expelling the injected gas. If there is any indication, one 14 x 17 film of the entire colon is then secured in the postero-anterior projection. We consider the above method of examination reasonably accurate when the lesions present are of an appreciable size and highly accurate in those measuring 1 cm. or more in diameter.

#### CANCEROUS AND POTENTIALLY CANCEROUS LESIONS OF THE COLON AND RECTUM

Boehme and Hanson<sup>1</sup> in a review of 1457 cancers of the large bowel, report 75 percent to have been in the sigmoid, the rectosigmoid or rectum, approximately 50 percent being in the rectum. They found the remaining 25 percent of the series almost equally distributed throughout the colon proximal to the sigmoid with the exception of the cecum, where slightly more than 6 percent of the total were located. Weber<sup>2</sup> reports approximately the same incidence, 49.9 percent being in the rectum and 70.5 percent being in the rectum, the rectosigmoid and sigmoid. He finds the incidence of polyps of the colon and rectum to be almost exactly the same in the analysis cited by him, there being 71.2 percent in the rectum, rectosigmoid and sigmoid, and approximately 28.8 percent proximal to the sigmoid.

In this communication we are concerned not only with cancers but also with precancerous lesions of the colon and rectum. All have come to recognize that polyps of the colon and rectum are always potentially malignant and should be so regarded. This does not necessarily mean that all polyps will become cancerous but if the patient lives long enough there is a very real probability that a relatively high percentage will do so.

The earliest manifestation of cancer of the large bowel has been a question that has aroused much interest and, in the minds of some, is still in dispute. Weber<sup>2</sup> quotes from a personal communication from Baggenstoss as follows: "Cancer of the intestine usually is manifest in its earliest recognizable stage of development as a polyp. Such a lesion may be sessile or pedunculated and the earliest histologic sign of malignancy may be present in its entire epithelial surface or only in a portion thereof." "Knowing how closely polyps of various parts of the colon parallel frank cancers in these same areas, although at a somewhat different age period, there can be little question of the importance of the earliest possible detection and adequate indicated therapy of all polypoid lesions of the large bowel.

#### COMMENT

Accuracy in diagnosis of cancer and potentially cancerous lesions of the colon and rectum is high when diagnostic measures available are intelligently employed.

The proctosigmoidoscopic examination is the most accurate and the primary method of examination in the area that can thus be inspected,

provided it is done by a painstaking trained examiner.

The roentgenologic examination is the most accurate and valuable single method of examination of the entire large bowel and is indicated in almost all colonic abnormalities regardless of findings by other methods.

A very encouraging percentage of those patients who have had cancer and have submitted to adequate indicated therapy are alive and clinically well at the end of five years. Patients are still dying from cancer of the colon, however, and, as physicians, we must ever be alert and spare no effort in training patients to consult their physicians promptly should colonic disturbances occur. Furthermore, when consulted, the physician must make certain that all indicated diagnostic measures available are employed and that necessary therapeutic measures are promptly instituted.

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## In Foreign Lands

In Recent Crucial Elections

90% of Belgians	✓ VOTED
89% of Italians	✓ VOTED
82% of Englishmen	✓ VOTED
70% of Japanese	✓ VOTED

## But in the U.S.A.

51% of Americans Voted in the  
Last Presidential Election!

**LET'S BE 100% AMERICANS**

**LET'S REGISTER and  
LET'S VOTE!**



# TREATMENT OF THE MALIGNANT LYMPHOMATA\*

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THE malignant lymphomata embrace a group of closely related conditions characterized by involvement of the lymphatic tissues and a uniformly fatal outcome. However, the cellular structure of these lymphatic tumors is extremely changeable, and transition from one apparently distinct type to another is frequently encountered. In addition, the clinical picture of these disorders may shade from one condition to the other, while different sections of the same gland or sections of different glands in a given case may show histological patterns considered characteristic of three or more of these entities. Many observers regard them all as mesenchymal tumors that vary only in degree and type of differentiation.

## CLASSIFICATION

Gibbons,<sup>1</sup> Coley,<sup>2</sup> and Oliver<sup>3</sup> have demonstrated the close relationship between Hodgkin's disease and lymphosarcoma. Herbut, Miller, and Erf<sup>4</sup> in describing six patients pointed out that at one time during their lives each one was diagnosed as having Hodgkin's disease and at another time lymphosarcoma; autopsy showed various combinations of Hodgkin's disease, lymphosarcoma, and reticulum-cell sarcoma. Custer and Bernhard<sup>5</sup> analyzed 1,300 lymphatic tumors, and their study confirmed and extended the opinion of the aforementioned authors. They felt that a rigid subclassification of lymphatic tumors was artificial and confusing. In the group of 700 patients in whom a diagnosis of Hodgkin's disease had been made, a virtually complete alteration in the histological pattern of the tumor was noted in 39 percent of the 138 autopsied cases and in 31 percent of the serial biopsy group (69 patients). Still more striking was the incidence of pure type tumors in these two groups in only

19 and 23 percent, respectively. When only one observation was possible either at autopsy or on biopsy, unmixed pictures were found in the majority of cases (74 and 71 percent). They concluded: "Analysis of 1,300 lymphatic tumors, many sampled several times during their progress, showed a striking fluidity in histologic pattern, with transitions and combinations that could best be interpreted as indicating a single neoplastic entity having a number of variants." The malignant lymphomata under discussion include Hodgkin's paraganuloma, Hodgkin's granuloma, Hodgkin's sarcoma, reticulum-cell sarcoma, follicular lymphoblastoma, lymphatic leukemia, lymphosarcoma and monocytic leukemia. No matter how these conditions are classified or treated the ultimate outcome is the same. As yet no cure has been found for any of them, although it is possible to prolong the period of gainful existence of the patient, to ameliorate symptoms, and, in some, actually to prolong life. Inasmuch as over 60 percent of the lymphatic tumors begin with painless enlargement of the cervical glands, frequently confined for a short time at least to one group of cervical glands, it is often difficult to distinguish these entities clinically. Biopsy of the affected glands is always indicated and is usually essential to establish a diagnosis.

## TREATMENT OF HODGKIN'S

Jackson and Parker<sup>6</sup> have divided Hodgkin's disease into Hodgkin's paraganuloma, Hodgkin's granuloma, and Hodgkin's sarcoma. Hodgkin's sarcoma and reticulum-cell sarcoma are considered identical by some.<sup>5</sup> Hodgkin's paraganuloma may be a relatively benign condition for long periods, but at any time may be transformed into Hodgkin's granuloma or Hodgkin's sarcoma. Enlargement of the spleen, and the onset of systemic symptoms such as fever, weakness, anoxemia or weight loss almost always

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indicate a transition to the more malignant forms of the disease. Jackson and Parker<sup>7</sup> recommend radical surgical removal followed by vigorous x-ray therapy in patients who have Hodgkin's paraganuloma or Hodgkin's granuloma when the disease can be shown to be confined to one group of accessible glands. It is rare, however, to find such a state of affairs. Hodgkin's disease in its early stages or when localized in the peripheral, mediastinal, or retroperitoneal nodes is best treated with x-ray therapy over the involved tissues. Regression of the glands, and constitutional symptoms if present, usually occur. The remissions so produced may last for many months. Return of signs or symptoms indicate that therapy should be resumed. The response to subsequent series of x-rays may be quite satisfactory, but eventually the disease becomes resistant to this therapy. Any unexplained, persistent sign or symptom in these patients must be considered as due to Hodgkin's disease and treatment resumed. The development of fever, generalized itching, gastrointestinal symptoms, and persistent polymorphonuclear leukocytosis indicates involvement of abdominal or para-aortic nodes and calls for further irradiation. In addition to early and to localized forms of Hodgkin's disease, bone lesions and obstructive lesions about the spinal cord, biliary tract, ureters, or great vessels, and fibrosing lesions are best treated with x-ray. Irradiation is also indicated when localized disease appears after a course of nitrogen mustard.

#### NITROGEN MUSTARDS

Various toxic chemicals have been found to be more destructive to actively proliferating cells than to normal tissues, and have therefore been used in the treatment of Hodgkin's disease. The nitrogen mustards belong to this group of chemicals. Methyl bisbetachloroethylamine hydrochloride (commonly called Bis and  $\text{HN}_2$ ) has had the most extensive trial of any of the nitrogen mustards. This chemical has been found to produce temporary remissions in Hodgkin's disease. These remissions vary from a few days to several months, but are usually not as long as those that follow x-ray therapy. Following preliminary studies, it has been ascertained<sup>8</sup> that  $\text{HN}_2$  is the treatment of choice in Hodgkin's disease when there is widespread involvement, marked constitutional symptoms (fever, night sweats,

pruritis, etc.), unexplained persistent fever, visceral involvement and lesions that have become resistant to x-ray. Nitrogen mustard therapy may occasionally restore radiosensitivity.

The usual dose of  $\text{HN}_2$  is 0.1 mg. per kg. of body weight daily, intravenously, for from four to six days. The drug is injected via a tube through which normal saline is being administered intravenously. From 200 to 500 cc. of saline is infused during each injection of nitrogen mustard. Nausea and vomiting follow injections of  $\text{HN}_2$  and usually last for three or four hours. Bone marrow and lymphoid tissue destruction are the most serious complications of therapy. Recurrence of symptoms necessitates re-evaluation and determination of the treatment of choice, remembering that when the disease is localized x-ray is best, and when it is widespread nitrogen mustard is preferable.

Triethylene melamine (TEM)<sup>9</sup> will cause temporary remissions in Hodgkin's disease when administered orally. In some cases it produces as good remissions in generalized Hodgkin's disease as nitrogen mustard, but the response may not be as extensive or as sustained. Nausea and vomiting tend to be less and the ease of administration is a distinct advantage. The usual initial dose is 5 mg. daily for three to four days. The medication is administered one hour before breakfast. The complications of nitrogen mustard therapy, such as aplasia of marrow, may also follow this medication. Subsequent courses of therapy should be regulated by the response to the first course and may be repeated within a week to ten days.

#### TREATMENT OF SARCOMAS

The response of patients having Hodgkin's sarcoma and reticulum-cell sarcoma to x-ray and nitrogen mustard is usually not as satisfactory or as prolonged, but the indications for their use are the same as for Hodgkin's paraganuloma and granuloma. Lymphosarcoma may react very spectacularly to x-ray therapy over the primary tumor. X-ray is the treatment of choice except in very widespread involvement when the primary tumor is not readily demonstrable. Vigorous irradiation over the primary tumor may be followed by disappearance of the other enlarged glands as well as of the primary tumor. Remissions so produced may be quite prolonged. Recurrence of enlarged glands demands further



treatment. It is often possible to prolong the life of the patient for several years, but at any time a rapid downhill course may develop. Nitrogen mustard or triethylene melamine therapy may be used when the involvement becomes widespread or when the disease becomes resistant to x-ray therapy.

Follicular lymphoblastoma (giant follicular lymphadenopathy) is probably the most labile of these disease entities and often pursues a benign course for many years. It must be considered to be a malignant tumor, which is usually highly sensitive to roentgen therapy, but is recurrent and progressive. It often undergoes transition to lymphosarcoma, reticulum-cell sarcoma, Hodgkin's disease, or lymphatic leukemia. Before transition x-ray is the treatment of choice.

#### LEUKEMIAS

Chronic lymphatic leukemia varies markedly as to rapidity of progress. In the older age group (over 50), for prolonged periods of time the patients may have few symptoms, no anemia, and only slightly enlarged lymph glands and spleen. It is often a relatively benign process. The high white blood cell count with a preponderance of relatively mature lymphocytes may be the only manifestation of the disease. These persons require no specific treatment and should not receive x-ray or other therapy until constitutional symptoms, progressive anemia, or increased glandular involvement make it necessary. Such patients may do well for many years, but at any time the disease process may gain momentum and active therapy become imperative.

Chronic lymphatic leukemia requiring therapy often responds very satisfactorily to x-ray over the enlarged spleen. The dosage and the frequency of treatment must be regulated for each individual. The direction of any change in the size of the spleen, liver, and lymph nodes, changes in bleeding tendency, level of the white blood cell count and hemoglobin concentration, and any variation in weight and in capacity for work should be considered as a guide to the need for additional therapy. There has been a leaning toward the use of smaller, more frequent doses of irradiation during the past few years. With frequent observation and small dosage, some physicians plan the treatment with an eye to the expected effect four to six weeks later. Radio-

active phosphorus ( $P_{32}$ ) likewise has been found to be effective in the control of the blood count and symptoms in chronic lymphatic leukemia. Some think it the treatment of choice. Osgood<sup>10</sup> recommends an initial dose of 20 microcuries per kilogram of body weight, followed in one to three weeks by a dose of 60 microcuries per kilogram. Control is usually achieved in six weeks. Maintenance doses of 6 microcuries per kilogram are then given, usually at intervals of ten weeks. The doses and intervals are adjusted to the individual patient. Osgood<sup>10</sup> considers that the most important criterion of an adequate maintenance dosage is whether or not the patient can carry on his usual activities in his usual way. The response of individuals who have chronic lymphatic leukemia to nitrogen mustard has not been found to be very satisfactory.

#### ANEMIA

In many patients the hemolytic process that develops may become quite severe, necessitating frequent multiple transfusions. Recently it has been found that the cautious use of triethylene melamine may markedly slow down the hemolytic process and decrease the need for frequent transfusions. Evidence of hypersplenism may become manifest during the course of chronic lymphatic leukemia. In such instances splenectomy may be of great benefit and may definitely prolong life.

The treatment of monocytic leukemia may prove quite difficult. Response to x-ray is limited and is often nil. Frequent transfusions may be required. Although spontaneous remissions do occur rarely, even a temporary response to therapy is the exception rather than the rule. Temporary remissions have been reported to follow nitrogen mustard therapy and urethane (up to 5 to 6 grams daily by mouth), but most observers have failed to note any clinical improvement following such therapy even when the white blood cell count fell rapidly.

During the course of any of these disease entities the development of severe anemia requires the administration of whole blood for relief. All patients having a lymphatic tumor are apt to be susceptible to infection and the frequent use of antibiotics is necessary, especially during the periods of leukopenia that may develop as a result

of the disease process or the therapy required for its control.

### CONCLUSIONS

The malignant lymphomata comprise a group of disease entities that are closely related and that often change from one apparently distinct type to another. No cure has been found for them, but it is possible to prolong the period of gainful existence of the patient, to ameliorate symptoms, and in some actually to prolong life by individualization of the treatment of the patient with the therapeutic agents at hand.

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## A TIMELY OBJECTIVE

We have no way of knowing exactly how many physicians in the Nation went to the polls in the last Presidential election, but we have heard that doctors in the past have not distinguished themselves in the matter of registration and voting.

Since 1948 the members of the medical profession have shown marked improvement in their voting performance and their interest in public affairs. However, we still have a long way to go. The objective in 1952—a critical year of decision if there ever was one—should be nothing less than a 100 percent registration and voting record by physicians.

Only about half of the eligible voters in this country exercise their privilege of voting in National elections. It is up to physicians to set an example and lead the way in the effort to improve that record. The more people who use that privilege, the longer it will last. Do your part: first, REGISTER then VOTE. And of equal importance, see that your family does the same.



# MALIGNANT TUMORS IN BONE

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A COMPLETE consideration of the malignant lesions occurring in bone is beyond the scope of this presentation. Rather, it is desired to provide a discussion of some practical use to the reader. We therefore wish to pose and discuss five general questions pertaining to such lesions. They are as follows:

- A. What are the common malignant lesions encountered in bone?
- B. When are they to be suspected?
- C. How are they approached for diagnosis?
- D. How are they treated?
- E. What are the prognoses?

## A. What are the common malignant lesions encountered in bone?

Classifications of bone tumors are numerous and are based largely upon the histologic types. While this is indispensable to academic study, the following classification has proved useful in clinical work:

Table No. 1—Malignant Tumors in Bone  
PRIMARY

- I. Fibrosarcoma
    - a. Periosteal
    - b. Endosteal
  - II. Osteogenic Sarcoma
    - a. Osteolytic Osteogenic Sarcoma
    - b. Sclerosing Osteogenic Sarcoma
    - c. Chondrosarcoma
  - III. Endothelioma (Ewing's tumor)
  - IV. Myeloma
    - a. Plasma cell
    - b. Myelocytoma
    - c. Erythroblastoma
    - d. Lymphosarcoma
  - V. Angiosarcoma
  - VI. Reticulum Cell Sarcoma
  - VII. Liposarcoma
- SECONDARY
- I. Osteogenic Sarcoma (including chondrosarcoma) occurring in primary benign bone lesions
  - II. Metastatic Carcinoma
  - III. Metastatic neuroblastoma

We have preferentially used the term "Tumors in Bone," for only a portion of them arise from connective tissue elements. This is reasonable, for any given bone is composed of "bone, the tissue," hyaline cartilage, and fibrous tissue. It is supplied with blood vessels and nerves, and is occupied in some areas by hematopoietic tissue and in other areas by fat and connective tissue. Thus a site of origin or a passageway for implantation of a variety of tumors is readily available. By and large, the greater percentage of malignant tumors encountered in bone will be one of the following:

1. Osteogenic sarcoma
2. Multiple myeloma
3. Endothelioma
4. Metastatic carcinoma

## B. When are they to be suspected?

## C. How are they approached for diagnosis?

A high index of suspicion is essential to early diagnosis. Early detection is in large measure the responsibility of the patient; but neoplastic disease occurring in bone is, as elsewhere, insidious in its development. Usually the patient will appear complaining of pain and sometimes of an associated tumor. Here, as in all of medicine, there is no substitute for a careful history and physical examination accurately recorded. A special emphasis is to be laid upon a search for evidences of infection; metabolic disease; endocrine disease; neoplastic disease, especially of the breast, prostate, kidney, and thyroid gland, as well as elsewhere; and any congenital deformity or pre-existent tumor. Any of these disorders may produce a tumor in bone, and a general knowledge of the patient's overall status is pertinent to accurate differential diagnosis.

In so far as approach to the specific area of complaint is concerned, the following points will be covered and carefully recorded: The date of onset of the complaint, its nature, and its relation to any other happening, especially trauma; any

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change in the symptoms, together with the time of the change and the interval involved; the time of appearance of any swelling or tumor and any change in its size or contour; the development of disability; and, of course, any other symptoms whether they be directly or indirectly associated with the area in question. In regard to trauma the patient will usually volunteer the information, but its significance in so far as any role it may play in etiology is as yet incompletely established. Trauma which postdates symptoms yet causes an aggravation of them is always significant.

If the local examination reveals swelling or an actual tumor, its location, extent, contour, and consistency should be noted. Other features to be recorded are tenderness to palpation; the color, texture, movability, and consistency of overlying skin; pulsations or bruit; the state of the circulation about the tumor and distal to it; the function of muscles and adjacent joints, or evidences of a fracture; and the presence of palpable masses in the area of regional lymph nodes. A neurological examination is to be considered an essential part of the total approach.

Proper and adequate radiographs are essential to diagnosis. Whatever skeletal structure be involved, at least two films made at right-angle planes to each other should be obtained, and they should include not only the area in question but a generous portion of the structures adjacent to it.

The routine measures of complete blood count, hemoglobin determination, and sedimentation rate are of distinct value as points in the differential diagnosis. Perhaps the single, most pertinent laboratory device to be included is the serologic test for syphilis! Additional, more refined laboratory procedures will be considered later.

While the foregoing studies may provide a diagnosis in some cases of bone tumor, in many others they will succeed only in posing a list of possibilities. To the end of more accurate establishment of the diagnosis, biopsy and histological study are still the final source of appeal. Even though the exact cell type of tumor may not be determined, at least there is usually established the presence or absence of malignant tendency and some concept of its degree. This most basic contribution usually serves as a guide for the selection of therapy and the speculation of prog-

nosis. Biopsy when performed should be attended by all of the attention to preparation, execution, and after-care that is ordinarily extended to a major surgical procedure. Wound infection and dehiscence is as disastrous here as elsewhere and it may seriously hamper definitive treatment. Aspiration biopsy has been advocated, but it must be remembered that the best biopsy provides a representative portion of the tumor mass. A negative aspiration biopsy is of little or no value.

Once a tumor in bone has been established to be of neoplastic origin, certain points from the history and physical examination may be used to suggest or even establish the correct diagnosis. We might here suggest four pre-existent benign lesions which show a tendency to undergo malignant change. They are: Giant cell tumors, cartilagenous exostoses, enchondroma, and Paget's disease of bone. The symptoms and findings when malignant change appears in them are similar to those of malignant lesions which occur in previously normal bone.

Pain is the earliest and most consistent complaint in malignant lesions in bone. Early it is mild and intermittent, gradually becoming more severe and persistent and often leading to disability. The pain is characteristically more severe at night, excepting in multiple myeloma, and often progresses to the point where narcosis is demanded for relief from it. A sudden increase in severity and associated disability may well arise from a pathologic fracture. This latter circumstance usually implies that the lesion is osteolytic and hence is encountered most frequently in metastatic carcinoma, osteogenic sarcoma, and multiple myeloma. If it should occur in the spine with associated compression fracture there may be evidence of greater or lesser damage to the spinal cord up to total paralysis.

Early in the course there may be only swelling of the part. If a palpable tumor mass is present, appears relatively oval in outline, feels rubbery or slightly elastic, and the overlying skin shows venous dilatation, the lesion may well be malignant. When the tumor is extremely large and of a similar consistency and the overlying skin appears to be bound to it and shows excessive venous dilatation, it is almost certainly malignant. Excepting Ewing's endothelioma, lymph node metastasis from primary malignant lesions of bone is uncommon. Venous implants are the rule



and may appear in the region of lymph nodes so that care must be made in their distinction. Marked weight loss, anorexia, cachexia, and severe malaise suggest far-advanced disease, usually with metastases.

Primary malignant tumors of bone or cartilage are principally a disease of the younger age groups, whereas multiple myeloma and metastatic carcinoma appear in the later ages. Secondary sarcomas which do appear in older age groups usually arise in some pre-existent benign lesion. The age of the patient and the location of the tumor in the skeleton is useful in suggesting the most probable diagnostic possibilities. Malignant neoplasm is rare in infancy. It is unusual in a child of preschool age where metastatic neuroblastoma is most frequently encountered. However, in this age diagnosis may be difficult because of the patient's inability to relate any reliable history or accurately describe symptoms. Careful attention then must be given to the differential diagnosis, for a host of growth irregularities, benign lesions, and infections are encountered. The following table suggests the dominant lesions encountered in each decade:

**Table No. 2—Malignant Tumor Incidence by Decade**

Age	Lesion
Infancy-10 yrs.	Metastatic neuroblastoma, Ewing's endothelioma, osteogenic sarcoma.
10-20 yrs.	Osteogenic sarcoma, Ewing's endothelioma.
20-30 yrs.	Osteogenic sarcoma, Ewing's endothelioma (a sharp decrease of incidence of the latter).
30-40 yrs.	Malignant aggressiveness or change in pre-existent benign lesions.
40-50 yrs.	Metastatic carcinoma of breast, multiple myeloma, osteogenic sarcoma (as malignant change in benign lesions).
50-60 yrs.	Metastatic carcinoma of breast, metastatic carcinoma of prostate, multiple myeloma.
60-75 yrs.	Metastatic carcinoma of breast, metastatic carcinoma of prostate. Sarcomas are rare.

A lesion simulating Ewing's endothelioma but occurring after the age of 30 is more likely to be a reticulum cell sarcoma. Fibrosarcoma and neurogenic sarcoma are unusual and tend to appear between the ages of 30 and 70. Angio-

sarcoma and liposarcoma are rare but have been reported between the ages of 8 and 50 years. Benign tumors usually appear in the first 15-20 years of life, but may not be detected for several years after development.

Certain generalizations are permissible regarding the susceptibility of various portions of the skeleton to malignant tumors. Osteogenic sarcoma arises chiefly in the long bones, and of these in the femur, tibia, or humerus in 80 per cent of all cases. Ewing's endothelioma shows essentially the same distribution. Metastatic carcinoma most often appears in the femur or humerus and rarely distal to these bones. Neuroblastoma frequently involves two bones across a joint. Malignant lesions of any sort are rare in the small bones of the hands or feet. The flat bones, including the skull, ribs, clavicle, scapulae, pelvis, and sternum, rarely develop primary malignant lesions except multiple myeloma. Metastatic carcinoma has a strong tendency to appear in these structures. The same is essentially true for the sacrum and spine.

The numerical incidence of lesions may be useful to the end of differential diagnosis. Lesions may be multiple, involving more than one bone, or plural by demonstrating several lesions in a single bone. It may be said that osteogenic sarcoma and fibrosarcoma are usually single lesions. Ewing's endothelioma is a single lesion early but because of rapid metastatic tendencies is often multiple. Metastases from carcinoma are often single early but may become both multiple and plural. Multiple myeloma is usually both multiple and plural. Metastatic neuroblastoma has been described by Coley<sup>1</sup> as multiple, plural, bilateral, and symmetrical.

The radiographic localization of the point of origin in a given bone may also aid in establishing a possible diagnosis. Certain tumors tend to appear in certain relationships to bone. Thus the central portion of the middle third of the shaft of a long bone is the common site for development of Ewing's endothelioma, and the central portions of the proximal thirds of the femur and humerus are sites of predilection for metastatic carcinoma. Osteogenic sarcoma most frequently develops eccentrically on or near the cortex in the juxta-epiphyseal area of a long bone. Fibrosarcoma tends to develop on the periosteal surface of long bones or occasionally in the endosteal portion. Chondro-

sarcoma has been shown by Geschickter<sup>2</sup> to show a distinct tendency for development at points where tendons are inserted, thus explaining its frequency in the adductor tubercle of the femur and the tibial tubercle, as well as the site of previously benign osteochondromas and enchondromas. The determination of the site of origin may offer some problem when the tumor is a large one; but since most tumors tend to grow from the center and are therefore spherical or gently oval, one may fairly accurately project the probable site of origin. This feature of growth and tendency of outline would suggest, therefore, that long or angular lesions which tend to follow the contour of the involved bone are not malignant. Ewing's tumor departs somewhat by often being much longer than it is wide. Lesions which develop in flat bones tend to involve the cancellus area and limited portions of the cortex unless they are far advanced and multiple, in which case both cancellus and cortical portions of flat and long bones may be involved. Tumors in the spine may defy detection until the bone is rather generously invaded. They are frequently collapsed from fracture which renders radiographic interpretation difficult. However, if the intervertebral disc is preserved, there is no evidence of abscess formation about the area, or there is evidence of destruction in the pedicles, one has strong evidence that the lesion is malignant.

A comprehensive discussion of differential radiography of individual bone lesions is beyond the scope of this effort. Rather than recite the features alleged to designate a given tumor, some effort will be made to describe patterns encountered which generally denote malignancy.

Unless the tumor tissue is forming bone or contains some calcareous deposit, it will not cast a characteristic shadow. Therefore, the character of the alteration which is produced in involved bone, together with the pattern of response (if any) elicited from uninvaded surrounding bone structures, will provide the means for interpretation of the radiograph. The principal points upon which we may rely in determining the presence of a malignant pattern have been enumerated by Ferguson<sup>3</sup> to be (1) the presence of active destruction and (2) the absence of evidence of infection. Destruction, as against decalcification, implies a loss of substance in pre-existing bone. Decalcification is a loss of calcareous material while the pattern of bone

structure remains intact. Active destruction is characterized by a loss of substance, the borders of which are roughened or granular, and show areas of partial destruction or invasion projecting into surrounding bone. Some lesions produce areas of destruction with clear-cut borders of essentially normal bone and they are characterized as being "punched-out." Single small lesions of this nature usually have no significance; but when they are multiple and especially when they are associated with some relatively large areas of destruction, one may suspect multiple myeloma or multiple metastatic carcinoma. Single large areas of destruction are most frequently associated with the osteolytic variety of osteogenic sarcoma or metastatic carcinoma.

Periosteum which has been stripped from bone by the expanding tumor mass may evidence some effort at repair. This effort is registered in the nature of an inert subperiosteal calcification, the density of which is usually homogeneous and with relatively small borders. It accounts for the appearance of a thin layer of calcification over the tumor mass adjacent to the involved cortex. If tumor growth is slow enough a number of such layers may be formed, giving rise to the so-called onion-peel appearance peculiar to either Ewing's endothelioma or osteogenic sarcoma. A remnant of this process may be seen in the so-called "cuff of bone" which appears on the radiograph as a triangular shaped portion of previously formed, inert subperiosteal calcification. The central portion of the layer appears to have been destroyed. The cuff tends to taper so that the apex lies peripherally where the periosteum has remained attached to bone. It is classically referred to as "Codman's triangle" and it has been mistaken to be peculiar only to tumors, whereas it has actually been encountered as a response of bone to many lesions. If its central border or base abuts against tumor tissue, and at this point there is evidence of invasion into it by the tumor tissue, it may be interpreted as strong evidence of malignancy. Therefore, inert subperiosteal calcification does not in itself denote malignancy, but invasion of it by adjacent tumor tissue does.

The presence of "tumor bone" is of marked significance. It may appear as a series of rays much like the teeth of a comb which are arranged more or less perpendicular to the surface of the involved bone. When this arrangement is



marked it gives rise to the so-called sunburst pattern. Tumor bone may appear as a series of coarse, angular, irregular calcifications within the mass of the tumor itself. When it is present and can be clearly identified, it of course denotes osteogenic sarcoma. Where tumor bone is quite massive within the tumor mass, it leads to the designation of sclerosing osteogenic sarcoma.

Expansion of a lesion while yet retaining an intact though thin cortex about it usually indicates a benignancy. Malignant tumors generally do not show such contained expansion. However, should there occur a spontaneous interruption in continuity of an expanded cortex, or a thickening of it especially with scalloping, malignant change is strongly suggested.

Exostoses which show a dissolution of their normal pattern with evidence of destruction and enlargement of their cartilaginous portions are probably undergoing malignant change, especially if the change is associated with the appearance of symptoms.

These are some of the radiographic signs of malignancy. When classic they may permit of accurate speculation as to the kind of tumor present. Ewing's endothelioma again tends to defy the general pattern described and often shows no actual clear-cut destruction. Rather there appears a haziness of outline with or without inert subperiosteal reaction as the only clear-cut finding present. In this instance one may have to rely upon the point of absence of signs of infection in order to differentiate it from osteomyelitis, which it also strongly mimics in its clinical and gross pathologic patterns. This radiographic change is designated as "lagging destruction."

Most lesions are osteolytic of pre-existent bone, but some—and notably metastatic carcinoma of the prostate—induce an osteoplastic response with marked increase in density. This finding is not to be confused with sclerosis, which shows increased calcareous deposit, but with retention of a normal bone pattern. An osteoblastic response, especially when located in the spine, pelvis, or upper femora, demands investigation.

The role of the laboratory in ruling out other causes for bone reaction has been pointed out. Five additional laboratory determinations may be utilized in the establishment of diagnosis.

These are the serum acid phosphatase level, the serum alkaline phosphatase level, and the serum calcium, phosphorus, and protein levels. A study of the urine for Bence Jones bodies is indicated where multiple myeloma is suspected.

Elevation of the serum acid phosphatase is usually considered pathognomonic for metastasizing carcinoma of the prostate. Elevation of the serum alkaline phosphatase above the normal for age and in the absence of liver disease implies unusual osteoblastic activity. Hence it is commonly elevated in metastatic carcinoma of the prostate and in roughly 60 per cent of cases of osteogenic sarcoma. A normal level is of no significance so far as neoplastic disease of bone is concerned. Elevation of the serum alkaline phosphatase where a giant cell tumor shows evidence of malignancy is considered to be a serious prognostic sign. Following the institution of treatment a fall in the alkaline phosphatase level implies a favorable response, while a persistent elevation—or a recurrent elevation—implies either recurrence of the lesion at its primary site or the presence of an active metastasis. Any extensive osteolytic lesion may produce an elevation in the serum calcium level, and it is only of corroborative value. Elevation in the serum proteins, of course, may confirm a diagnosis of multiple myeloma.

Even after careful evaluation of the findings from such studies, diagnosis may not be established. The resort to biopsy is then, as always, justifiable. Accurate interpretation and evaluation of the histologic picture is always facilitated if the above information and laboratory findings are at the disposal of the pathologist. Still it may be quite impossible to establish exactly what class of tumor is present; but the disaster of sacrificing a limb because of a misinterpreted benign lesion, or the even more devastating error of expectant treatment applied to a misinterpreted malignant lesion, will have much less chance to occur.

#### D. How are they treated?

The unfortunate truth is that there is no single therapy which can be applied with universal success at any time in the natural history of these lesions. Success here, too, is measured in terms of survival periods. Those implements which are available succeed best in cases treated early. Hence a very real part of any treatment

program is early detection and diagnosis. Basically cure is obtained either by sterilization of all tumor cells in situ or by eradication of all tumor cells by subtraction. The implements available include (1) surgical excision, (2) amputation, (3) hormonal therapy, (4) radiation including x-ray, radium, and the radioactive isotopes. So far as the radioactive isotopes are concerned, they are so new that a worthwhile evaluation of their effect has not yet been established. Some of them, and particularly radioactive gallium, hold much promise.

Surgical excision is almost entirely limited to fibrosarcoma of low grade malignancy. Careful judgment is to be exercised in selecting cases for such treatment.

Amputation is still the most widely used form of treatment in most primary malignant tumors of bone. The objective of amputation is to remove all of the primary lesion and to prevent metastases (or further metastasis), and it is executed at a high enough level to preclude danger of local recurrence. Aside from the quality of malignancy, a fungating lesion or a useless limb disabled by extensive bone destruction and pathologic fracture may well justify amputation even in a hopeless case. By virtue of common sites of development of these lesions, the common levels for amputation are the mid-thigh in the lower extremities and the interscapulothoracic level in the upper extremities. Extensive amputations are now carried out with a wider margin of safety than was at one time possible.

Hormonal therapy is largely applied to carcinoma of the breast and prostate as primary treatment. In many cases where metastases have already developed and are responsible for symptoms, there may be marked improvement in so far as the osseous system is concerned. By and large this means of treatment is directed at management of the disease and palliation rather than its cure. The intricacies of it have been discussed elsewhere.

Radiation of any kind has a two-fold application and may be directed either toward a cure or the management or palliation of far-advanced cases. Its success in the sterilization of tumors is, of course, proportional to the sensitivity of that tumor, for the dose which may be required to assure eradication of tumor cells may far exceed the tolerance of normal tissues which surround

them. The consequence of overdosage may be quite devastating. In general, the more malignant the tumor the more radiosensitive it is. Yet wide variations exist within apparently similar histologic types with similar degrees of malignancy. Application of this medium to the treatment of tumors in bone has, as elsewhere, resulted in the observation that certain of them showed consistently better response than others.

Of the primary tumors in bone Ewing's endothelioma dominates the group so far as response in a given single lesion is concerned. However, its tendency to very early metastasis may well defeat the success of the overall control of the disease. Reticulum cell sarcoma responds as readily as does Ewing's; and since it tends to metastasize relatively later, a greater degree of success in survival has been realized. Metastatic lesions from these two tumors also generally respond favorably for a time.

It may be said that neither osteogenic sarcoma (including chondrosarcoma) nor fibrosarcoma is amenable to cure by radiation either at the primary site or in areas of metastasis. Only where amputation is refused or the disease is hopelessly advanced should it be advised and then only for whatever palliation may result.

Radiation of multiple myeloma is usually hopeless as far as cure is concerned, but has been used palliatively and often with success. Metastatic carcinoma varies widely in its response to radiation and since the response cannot be predicted its usefulness is established empirically in each case. It may be of special value where pathologic fracture has occurred, in that a response by the tumor mass to radiation may permit of union of the fracture, but the dose must not be so high as to depress bone formation.

The value of radiation therapy in the rare angiosarcomas and liposarcomas has not been established.

Beyond these points treatment is general and supportive. Benefit may accrue from treatment directed at the primary disorder but will not be considered here. The hopeless and fatal case is a problem which is all too frequently encountered and its problems are well known.

The pathologic fracture is a grave prognostic sign in primary tumors of bone, and it is a disturbing complication in an area of metastatic carcinoma. In the former case, when amputa-



tion is not carried out at once the limb should be splinted. It may be wise to institute some x-ray treatment to preclude spread in so far as is possible. In metastatic lesions with fracture through the shaft of a long bone the use of open reduction and intramedullary nailing, with or without radiation, has provided excellent palliation in many cases and resulted in union in some of them. No untoward results have been encountered and the relief from the additional burden of pain which such a fracture may impose is gratifying, both to the patient and the physician.

### E. What are the prognoses?

Fibrosarcoma of low grade malignancy may show persistent cure especially if amputation has been carried out early. As the grade of malignancy rises, the percentage of cures drops.

Of the osteogenic sarcomas treated by amputation, the sclerosing variety offers a somewhat greater chance for five-year survival than does the osteolytic variety. Geschickter<sup>2</sup> reports 21 percent of five-year survivals in the sclerosing variety and 16 percent in the osteolytic variety in his series. Metastases produce the fatal outcome. The same generalization holds for chondrosarcoma where secondary varieties show a higher survival rate than do the primary forms in well-controlled series. Ewing's endothelioma is almost invariably fatal since in its insidiousness it tends to early metastasis, often before detection of the primary tumor. Coley<sup>1</sup> states the average duration of life to be two years. Reticulum cell sarcoma metastasizes later and consequently shows

a much higher percentage of survivals when the primary tumor was detected early and treated adequately. This point should urge the careful differential diagnosis of these two similar tumors.

Multiple myeloma is invariably fatal, with an average survival of 18 months from the onset.

Metastatic carcinoma is but an expression of the gravity of the primary disease and prognosis is measured in terms of it.

### SUMMARY

The substance of this effort has been to suggest an awareness of tumors, and an approach to them in terms of recognition and diagnosis. The concept of susceptibility in various age groups and in various portions of the skeleton to the development of malignant disease is suggested, rather than the concept that certain tumors themselves select certain areas for their development. For when the patient appears and is examined and studied, all of the features about the disease may be learned except the last and basic bit of information, namely, what the tumor is. The title thus appears at the end of a case history, but at the head of a textbook chapter.

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# THE JOURNAL

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## WHAT SHOULD A PATIENT WITH MALIGNANCY BE TOLD?

**T**HIS all-important question has troubled physicians and harassed the relatives of doomed patients ever since malignant tumors were first recognized. In spite of centuries of experience, there still exists no uniformity of opinion on all aspects of this complicated problem.

Advancements in the diagnosis and treatment of malignancy have made necessary the discussion of the diagnosis in certain situations, and it is in these situations that professional opinion is almost unanimous.

If symptoms and physical signs suggest the possibility of a malignant tumor, the patient should be told enough to allow a decision for specialized examinations and/or biopsy. Often, mere mention that further diagnostic procedures are advisable is sufficient. If specific reasons are not required it is well to spare the patient the anxiety which open discussion is sure to produce.

Patients often recognize the rationale of such investigations and are willing to proceed. Telling these patients of the possibility of malignancy does not aid the diagnosis, but will increase their anxiety.

However, if a nonspecific recommendation does not produce the necessary consent, the patient undoubtedly should be told that the additional examinations are advisable in order to rule in or rule out malignancy. No patient should be allowed to curtail a full diagnostic investigation, without being acquainted with the reasons, so that his or her decision will be based on a full knowledge of the facts and possibilities.

If a diagnosis of malignancy (or as reasonable a diagnosis as is possible by means short of a major operation) has been made, it is usually necessary to tell the patient the facts as exactly as they have been determined. This is necessary



in most instances in order to justify either a radical operation or prolonged radiation therapy. Most people react well to this information and it is generally recognized that it is inadvisable to attempt to treat a person for malignancy and pretend that the condition is benign.

As is the case in every illness, each case must be individualized. The above observations commonly do not apply to children. In every case the information should be imparted in a way which avoids fear as much as possible but is still truly informative. Reassurance which is justifiable should be included. The word cancer is best not mentioned unless the patient speaks it first.

The greatest divergence of opinion among physicians and laymen exists in the case where it has been determined that the malignancy is incurable.

If the patient is the head of a household or has other serious responsibilities the obligation to acquaint him with the true situation is almost absolute. Many doctors and most laymen recognize this as a moral and ethical responsibility which cannot be avoided.

In the case of others with incurable malignancy there is a tendency to avoid a factual explanation and often an organized effort is made to explain the clinical picture on the basis of a benign condition or to represent the operation or other treatment as curative. The difficulty with this procedure is that, in spite of the most artful explanation, and despite the most devious and clever management, the patient will eventually reach a clinical state which he recognizes without doubt as a fatal one.

At this stage it is as difficult (or even more so) to be honest with the unfortunate as it was originally. He realizes that he is incurable, and all the reassurances given by his doctor and relatives must appear to him as deceitful and somewhat short of satisfactory, however well-intentioned they were at the time. Such a person must leave this life with a feeling that he has been deprived of friendship at a time when it means the most.

Doubt and fear may be more devastating than a knowledge of the true facts, even though the true facts in the case of incurable malignancy are certainly not the best. A patient who wishes to know what his condition is, is often actually relieved to know the bitter truth.

In this connection it has been observed that people vary in the persistence with which they seek the truth when they suspect that a malignancy is incurable. For this reason it is well to answer their questions as soon as they are put, but to do so originally in a general and nonspecific fashion, without stating any actual untruths. Some people will not ask for more detailed information, and apparently derive a considerable amount of comfort from an indefinite answer. When the truth is hinted at but not stated too specifically the patient may always entertain in his mind the possibility that all hope is not lost.

Other people, however, are aggressive in their questions, and continue to seek the detailed facts. For these it is probably better to furnish honest answers, on a grudging scale, so that the quest for truth may be abandoned at any time, and leave that lingering doubt which is some comfort at least. Some will pursue the facts until a complete story has been given them, and will feel better for it.

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## CANCER OF THE STOMACH

**M**ASS x-ray surveys have been proposed as one means of improving the early diagnosis of gastric malignancy. Several large series of unselected patients have been subjected to roentgenographic screening techniques in an effort to determine whether an examination procedure could be reasonably diagnostic and at the same time could be economical enough in time and money to warrant its routine use.

A report was made recently of a four-year survey of 10,000 persons over 40 years of age, conducted at Johns Hopkins Hospital in Baltimore. A photofluoroscopic examination was utilized. This method does not require a roentgenologist except for interpretation of the film. The examination may be conducted by a technician, and the cost of the film is not excessive.

Films which were considered diagnostic were obtained in 90 percent of the cases. However, in spite of the excellence of the films and the low cost of the method, the series was reported as disappointing.

Malignancy was diagnosed by the method, corroborated by standard technique, and con-

firmed by operation in only 27 of the 10,000 cases. Many of those operated upon in this group were symptomatic, several were inoperable.

There were 27 other cases in which evidence of malignancy was picked up by the photofluoroscopic method and corroborated by standard technique, but in which confirmation has not been possible because the patients refused operation. Most of this group are asymptomatic.

The effectiveness of the survey was greatly depreciated by the fact that only a few of the patients with positive x-ray findings could be induced to submit to operation prior to the onset of symptoms.

As further indication of the tendency to ignore positive diagnostic findings in the absence of symptoms, there were 185 patients in the series whose photofluoroscopic plates suggested carcinoma, but who could not be induced to return for regular gastrointestinal series.

Since the prime object of the survey was to discover cancer in its presymptomatic and curable stage, it is evident that, as the authors concluded: "It appears that the general public must receive further education concerning the gastric cancer problem before photofluorography will be successful."<sup>1</sup>

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## INDUSTRY AND EDUCATION

**T**HE National Association of Manufacturers recently announced that it "has launched an unprecedented campaign to rally business enterprise to provide additional funds to maintain and improve our educational institutions."

The announcement was made after a thorough study of the situation had been completed by the Association's Educational Advisory Council and Educational Advisory Committee. Unanimous action of the 160 member Board of Directors, representing the more than 17,000 member companies of the N.A.M., adopted a resolution which stated in part "Business enterprises must find a way to support the whole educational program—effectively, regularly and now."

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<sup>1</sup>Roach, John F., Sloan, Robert D., and Morgan, Russell H.: The Detection of Gastric Carcinoma by Photofluorographic Methods. *Am. J. Roent., Radium Therapy, and Nuclear Medicine*, 67:68-75, Jan. 1952.

The financial plight of our country's schools is the result of inflated costs, decreased endowment income and the loss of support which private fortunes afforded in days gone by. The N.A.M. has taken an interest in education for many years, but recently began to explore the possibility of setting aside some part of industrial earnings in order to provide a substantial and continuing support for education.

The N.A.M. Educational Advisory Council is made up of educators, who represent all levels of both public and private education. The Rev. John J. Cavanaugh, President of Notre Dame University, is one of its members.

The N.A.M. Educational Advisory Committee is composed of industrialists from all parts of the United States. These two groups have worked together in studying the problem and in propounding a solution for it. C. E. Hamilton of Richmond, Indiana, and A. C. Conde of Indianapolis are members of the committee.

The public-spirited stand of the manufacturers' association has received the plaudits of educators and leaders from all walks of life. Those who are interested in preserving the freedom of medical education and of education in general are commending the industrial leaders for a philanthropic program of tremendous practical importance.

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## COOPERATION IS THE BEST WAY

**T**HOSE living behind the iron curtain who are victims of sickness, accidents, disaster, and circumstances are frequently ignored, and even scorned by their fellow citizens. "TAX LEVIES" would be that government's answer to any service provided to the crippled.

It is difficult for international organizations to extend a helping hand, although they would in many instances, but the lack of cooperation on the part of totalitarian governments and from their citizens, too worried about their own welfare, makes it impossible.

Such is not the case in the United States where many benevolent organizations conduct voluntary campaigns for funds to develop facilities and direct services to the victims of tragedy and circumstances. Agencies like the Indiana Society for Crippled Children spend a great deal



of time and effort in the interest of general public welfare. Their funds, derived from Easter Seal Contributions, are used for any needed service which will lead to the rehabilitation of a crippled child or adult.

One of the greatest democratic privileges enjoyed by American citizens is that of helping fellow Americans, voluntarily and whenever the need is apparent.

The American public in recent years has changed its attitude almost entirely toward crippled children and adults—thanks to our medical men, who work long hours and many times risk their own health to bring to their crippled patients the best possible physical restoration. Public and voluntary private agencies spend long hours learning the needs of each crippled individual and developing facilities, always with the guidance of the medical profession, to meet those needs.

Today the crippled are a useful part of our world, making their contributions to the professions, to business, and to industry. Many little crippled girls and boys who today are attending the nursery school, provided by the Society for Crippled Children, will be the young men and women of tomorrow seeking employment and a useful self-respecting place in their communities. Most of them can be rehabilitated to become a tremendous national resource by scientific rehabilitation and human understanding to make them productive persons.

March 13 to April 13 is Easter Seal month when all can help. The citizens of Indiana have proved time and again that they are aware of the important privilege of helping those in need.

In Indiana, public health and welfare organizations are not duplicating service or competing in any way. They are all working together, with the help of the members of our medical association, to bring a complete program of rehabilitation to the crippled and disabled of our state.

It takes cooperation, all through the ranks, to make America's "voluntary" system work.

*Indiana Society for Crippled Children*

## Editorial Notes

The National Fund for Medical Education reports receipt of \$1,799,188 as contributions in 1951; \$745,917 of this came from the American Medical Education Foundation of the A.M.A., the remainder from business and other corporations. Unrestricted grants of \$1,594,373 were made to medical schools last year.

H. J. Anslinger, U. S. Commissioner of Narcotics, recently issued a warning in regard to the addicting powers of synthetic analgesics. He emphasized that whatever advantages may have been achieved in the discovery of synthetic narcotics now available, science has not yet produced the ideal drug of this group—a synthetic pain-relieving drug that will not have addiction liability.

The A.M.A. is studying a proposal that patents on medical discoveries be pooled by physicians, and that the royalties be turned over to the Medical Education Foundation for the benefit of medical schools. If the plan is found to be legally possible it will furnish a considerable income for aid to medical education.

On May 5, 1952, at 8:00 P.M., Paul Coble Post of The American Legion is sponsoring a general meeting in the World War Memorial to which all physicians and dentists in the state of Indiana are cordially invited. This meeting will be addressed by Dr. H. D. Shapiro, Professor of Psychiatry at George Washington School of Medicine, Washington, D.C. Dr. Shapiro is also the Chief Medical Consultant of the American Legion. The second speaker will be Mr. George N. Craig, Past Notional Commander of the American Legion, a practicing attorney in Indianapolis and for the past year one of the legal counsel of the American Medical Association.

The subject of the discussion at this meeting will be the medical care of veterans, especially the care of non-service-connected cases of the Veterans Administration. The American Legion's stand on the section of the Hoover report affecting the Veterans Administration will also be discussed. Both of these speakers are national authorities on these subjects and will come prepared to give facts and figures and expect very active audience participation.



## President's Page



IT WAS my privilege recently to be the guest of the Indiana State Veterinarian Medical Society to discuss with them some of the communicable diseases common to animals and humans.

Preceding me on the program was Charles E. Titus, M.D., of Wilkinson, Indiana, who compared the "horse doctor," as the veterinarian was designated fifty years ago, with the present-day veterinary medical man.

Perhaps to a great many of you, especially those who have had the advantage of enjoying a practice in a rural district, some of the activities which interested me will be "old stuff." Yet I could not help but observe a great deal of similarity between their convention and our own annual meeting.

With the assistance of my good friend, Dr. Gerald Kempf, who was the health commissioner of Indianapolis, I learned that there are more than seventy diseases which the human may contract from animals. This bit of information was enlightening; however, I will not attempt to enumerate them now.

As at our own convention there were exhibitors with their particular products to encourage a better grade of live stock for the consumer; there were scientific papers on the newer methods of surgery and experimental studies in feeding.

A very fine talk was given by a gentleman from Michigan on an experiment in hay. That might seem like a simple subject, but loads of hay were delivered to the experimental station in Michigan from various parts of the country, and examined in the laboratories and on the feeding lots to determine the best product possible for feeding in order to produce the best in milk and meat.

Time and space will not permit a more detailed report on the activities of the Veterinarian Medical Convention, but I am certain that we do have a number of ideas in common. They as we are continually sponsoring legislation, such as control of Bang's Disease and other measures for the betterment of health in general, at the expense of our own pocketbooks.

Six years are now required for the education of a veterinarian, and yet there are those inadequately trained who would attempt, by law, to qualify themselves as competent to treat human ills with much less preparation.

We congratulate the Veterinarian Medical Association on its progress.

*William Wright*



## INDIANA MEDICAL EDUCATION FUND

*I*NDIANA is again assuming leadership for the nation in its effort to assist our medical schools through the National Medical Education Foundation. Reporting contributions of more than \$22,000 to the American Medical Association as of February 16, 1952, the Indiana State Medical Association has been informed that it is leading the other states in contributions received during the year 1952.

As good as this may sound, Indiana's record is not what it appears to be, as most of the other states sent sizable contributions during the year 1951, while Indiana sent less than \$1,000 during that time.

Since the meeting of the House of Delegates in October, the Committee on Medical Education and Hospitals has been making a serious effort to attain the goal of \$100,000 set for Indiana. Kicking off the campaign, the House itself contributed more than \$8,000 to set the pace for the campaign. Since that time every physician has received a pledge card and an appeal for a contribution; several have answered this appeal, but a great majority have not. Those who have not sent their gifts will be contacted personally following the April meeting of the House, as the goal must be reached and every member reported upon by the first of June, which will close the year of effort on the part of the AMA.

The campaign has more far-reaching implications than may meet the eye at first glance. It is for this reason that the committee is making such a strenuous effort to reach the goal established for Indiana.

Everyone is well aware of the economic situation today; we all have experienced the shrinkage in the value of our dollars. This same experience has been felt in the medical education field.

We do have to be reminded that the money we as students paid in tuition came nowhere near paying the cost of our education. The balance of this cost was met through taxation in the case of a state-supported school, and through private gifts and endowments in the case of the private school. The economic situation has made both sources inadequate to meet the demands of present-day costs; this is the reason this appeal is being made.

It has been proposed by some, in desperation no doubt, that the Federal Government be urged to step in and meet this deficiency through federal grants. The issue that becomes involved is simply this: medicine feels that should this be permitted we become as guilty as anyone else in shifting our responsibilities to the government. This is the very thing we have been complaining about for the past several years. Government has had everything shifted to it that the public has not wanted to be troubled with, such as welfare, insurance, hospital and medical care. The government cannot always be blamed, because they have followed the wishes of some of the people when the people themselves have made no effort to solve these problems. The questions are then, is medicine to join in asking the government to take over the financial support of medical schools; are we to shift this additional responsibility to government; are we to be a party to increasing taxes to carry this additional expense; are we to join in making the government more indispensable in our economic life; are we to strengthen the position of government in providing for us and our needs? Which is socialism, by whatever name you call it.

It therefore becomes our job to prove that the medical profession is a believer in what it says: "That all problems can be solved by the people at the community level," and we should not delude ourselves with the false belief that paternalism by government is best for the country.

The committee makes this one appeal: we want to finish our campaign by being able to say that every member of our association gave to this cause. While we want you to give as much as you possibly can, as this will be necessary if we reach our goal, nevertheless we hope you will not refrain from giving because you feel your financial position will not permit your giving as much as your friends. If you can only spare a dollar, send it in; it will make the Indiana campaign a total effort; it will prove that every physician in our state is participating in this great effort to prove that the individual can and will accept his responsibility, that medicine has not joined the ranks of those who say "Let the government do it, I'm too busy."

J. W. DENNY, M.D., INDIANAPOLIS,  
*Chairman, Committee on Medical Edu-  
cation and Hospitals*

## TRIBUTE TO MAX A. BAHR, M.D.

### On the Occasion of His Retirement as Superintendent of Central State Hospital

**D**R. MAX A. BAHR resigned as superintendent of Central State Hospital to go into retirement on March 15, 1952.

Doctor Bahr was born and educated in Indianapolis. He received his M.D. degree from the Central College of Physicians and Surgeons of Indianapolis in 1896. After a residency at the Government Emergency Hospital in Washington, D.C., he affiliated himself with Central State Hospital on March 1, 1898, where he served first in the capacity of assistant physician and clinical psychiatrist.

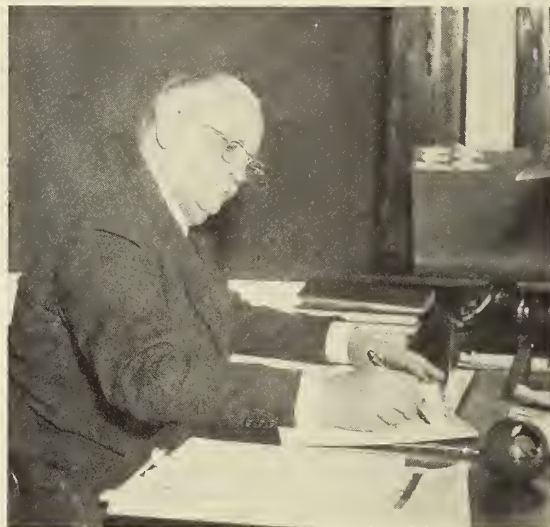
In 1905 he did a year of postgraduate work in psychiatry at the University of Berlin, Germany, where he was granted the degree of doctor of psychological medicine.

Following the death of Dr. George Edenharter in 1923, Doctor Bahr was advanced to the position of superintendent. Under his leadership the institution soon became nationally prominent and toward the end of his career he found himself at the helm of one of the best known mental hospitals.

As superintendent Doctor Bahr's work was mainly taken up by administrative duties. However, he always maintained an acute interest in clinical and research work.

His first significant contribution to the field of medical science was in 1920 when he described in *The Journal of the Indiana State Medical Association* a so-called "endothelioma." Doctor Bahr's case was one of five such brain tumors which were described in the literature and which started Cushing on the new classification of the tumors arising from the meninges. Tumors of this kind are today known as "meningiomas." The tumor specimen of Doctor Bahr was reproduced in Cushing's (1927) monograph on "The Meningiomas."

From 1900 to 1930 Doctor Bahr did most of the teaching in psychiatry which a medical student received in those days. To Indiana physicians he is best known for his famous Saturday afternoon clinics and lectures, which were given in the amphitheater of the Central State



Doctor Bahr at his desk, preparing a lecture.

Hospital. For a number of years Doctor Bahr held the post of chairman of the Department of Psychiatry and Neurology of Indiana University School of Medicine.

It is a fact that in Indiana, through the teaching of Doctor Bahr, the average physician had a better knowledge of mental illness than in most other states, because in the first two decades of this century there was practically no teaching in this branch of medicine which has become so important today.

The relationship between crime and mental illness has always been of great interest to Doctor Bahr, and the first clinical course in forensic psychiatry to attorneys and judges was given at Central State Hospital, in consequence of which he was elected an honorary member of the Medico-Legal Society of New York.

He also conducted a course for psychiatric social workers and for student nurses. In those early days these were pioneer activities in psychiatry, which were unheard of in most other states.

Among Doctor Bahr's many scientific accomplishments, the work on the malaria treatment of general paresis is probably the best known. Being first to use this treatment on a large scale



in this country, Central State Hospital of Indianapolis has frequently been referred to as the Home of the Malaria Treatment in America. The local hospital established a service by which physicians throughout the country were able to obtain a certified strain of malaria to carry out this treatment. Through publications and particularly through the medium of scientific exhibits, which were shown at national and state medical meetings, the institution familiarized others with this mode of treatment. In this way many patients were saved from dementia and death.

At the International Symposium on the Malaria Treatment which was held in Breslau, Germany, in 1931, a detailed account was given by the local institution on the question of why malaria brought about a cure in general paresis. Up to that time only vague ideas had been expressed.

While the malaria treatment in this country was born, so to speak, in Indianapolis, it was also buried there. With the advent of penicillin the National Research Council furnished the institution with this antibiotic long before the drug was available for civilian use. In 1949 Central State Hospital was able to come out with the statement that penicillin, when given in appropriate amounts, was equal or even slightly superior to the malaria treatment. This marked the end of malaria therapy. Based on clinico-anatomic studies, new and higher penicillin schedules for the treatment of neurosyphilis were developed at the local hospital, which are finding rapid acceptance throughout the nation.

Another piece of research of enduring value, which was carried out under the leadership of Doctor Bahr, concerned the relationship of rheumatic fever to certain psychotic states. This investigation was initiated with a grant by the Supreme Council, 33°, Northern Masonic Jurisdiction.

The study brought out the continuity of rheumatic fever in a chronic or subclinical form which in some individuals endured throughout the lifetime. Although the original attack of rheumatic fever had taken place sometimes decades before, mild activity could still be demonstrated in the tissue of the heart valves. Likewise, in the brain and in other organs occlu-

sive vascular changes took place, which in the nervous system produced various psychiatric and neurologic manifestations. This condition has been termed rheumatic brain disease, and has since been confirmed in this country and abroad.

The importance of this work lies in the fact that for the first time in over 40 years a new causative factor has been established which is responsible for the production of a considerable number of mental cases each year.

The work on the rheumatic psychoses was demonstrated at the Sorbonne University in Paris, France, in 1949, in connection with the International Congress of Neurology.

Doctor Bahr, always alert to new developments, organized as early as 1938 a special ward for the deep coma insulin treatment of dementia praecox. Electric shock therapy was used as soon as the necessary safe equipment became available, and at the moment he is opening a brain wave laboratory which will become an important adjunct in psychiatric diagnosis.

Twenty-five years ago Doctor Bahr had a large occupational therapy going at the institution, conducted by one of the few trained therapists who were available at that time. For many years past the principles of psychotherapy have been utilized at Central Hospital, which Doctor Bahr brought back years ago from his postgraduate studies in Europe, where Freud and Adler and Jung had just made their important contributions to the field of psychiatry.

Doctor Bahr was president of the Indianapolis Medical Society in 1932 and served on various committees and as a delegate to the Indiana State Medical Association. He is a member of several neuropsychiatric organizations.

Only recently the American College of Surgeons, following a survey of the institution, paid Doctor Bahr one of the finest compliments. It said: "In spite of the continuous handicaps of a limited budget, Central State Hospital has gained a preeminent place as a contributor to the science of psychiatry and mental hygiene."

As physicians we like to think of Doctor Bahr first as a gentleman, then as one of the finest public servants the state of Indiana ever had, and finally as a great doctor and administrator who has shown diplomacy, tact and firmness in dealing with the many problems encountered in these troublesome days.

## WHY VOLUNTARY HEALTH AGENCIES?

ROLLIS S. WEESNER\*

*Indianapolis*

**N**OWHERE in the world do voluntary health agencies flourish in such abundance as they do in the United States. Not only are they an expression of charitableness, but testimony to the free and democratic spirit of Americans. They demonstrate the organizing and cooperative abilities of people seeking common good.

The profession of medicine, like law and religion, would not exist if it were not for this broad interest and the needs which are manifested so thoroughly in the interest and activity of so many people in these movements.

The steady advance of government into the field of welfare activities is stimulated, and a natural result, from widespread voluntary interest and demonstration. Theoretically, the voluntary demonstrations, when good, should be taken over by government. Actually, however, the cloak of welfare too often becomes "mink" and tends to cover Karl Marx. This very trend, if not held in check, could well mean the end of voluntary health and welfare agencies. It would also be the end of the free practice of medicine.

Too many people now are asking themselves: Why should we continue to support voluntary agencies? Why not let the government do it all? We pay enough in taxes.

Ex-President Herbert Hoover says: "The first short answer to this question is that you cannot retire from the voluntary field if you wish our American civilization to survive. The essence of our self-government lies outside of political government. Ours is a voluntary society. The fabric of American life is woven around our tens of thousands of voluntary associations. That is, around our churches, our professional societies, our women's organizations, our businesses, our labor and farmers' associations—and, not least, our charitable institutions. That is the very nature of American life. The inspirations

of progress spring from these voluntary agencies, not from bureaucracy. If these voluntary activities were to be absorbed by government bureaus, this civilization would be over. Something neither free nor noble would take its place."

There are other answers that are quite obvious to thinking persons, such as: morality, which is gained by free and independent action; dignity and character, which cannot be created and sustained by a government agency; charity—a religious precept—which cannot be taken from the hearts of people without at the same time damaging their souls. And who would set the standards for the government bureaus' programs? Haven't privately owned and managed hospitals, educational institutions, and voluntary institutions set the pattern and shown the way? Without them our governmental health and educational agencies would wither.

### WOULD AMALGAMATION BE GOOD?

Another question often asked is: Why not combine all the health organizations into one super-agency? Such an organization would help to prevent overlapping and duplication; would be more efficient and economical, and would make necessary only one fund drive each year, the proponents say.

There is good argument for the practical idea of amalgamation. This would undoubtedly be a boon to the subjects which have not been highly organized and sold to the giving public. Some of these causes are highly important and deserve more funds and more attention than they now get, and some of the older, well-established agencies might well share their wealth with them. *But*, would this not tend to defeat the very philosophy of the voluntary instinct that we must keep alive in American society?

Our people are inclined to choose their interests. If these choices are removed, interest de-

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clines. The machine age ruined the crafts; if there were only baseball in the sports field, would not sports suffer, and so on? Also, is not the essence of freedom contained in opportunity to select, serve and give where one chooses? One agency would reduce greatly the opportunity for large numbers of people to participate. Health agencies and other voluntary welfare organizations provide releases for the impulses of charity, concern and comradeship. They can become "hobbies" and have valuable therapeutic effects on many people.

For these reasons and many more, we should go slow in recommending the amalgamation of our "causes" into one big cause that could well lose its color and appeal. And remember, one big agency could easily develop into a quasi-governmental bureau and then when people's interest and support waned, the government would take over.

#### FEDERATION—SOMETHING ELSE

The federation of agencies for the purpose of soliciting funds is quite different from amalgamation. Even here, however, some of the same pitfalls are inevitable.

Federation does not destroy the individual agency, but proposes to join efforts in the raising of money so that solicitation costs are reduced and the nuisance of repeated appeals to the public is stopped. If, however, the privilege of the individual agency to create its own budget is denied and placed in a super-planning board, we may soon be in the same position as amalgamation, and fewer and fewer people will feel that they are needed and their interest and support will decline. The prime objective of the "big drive" becomes money only and not the "causes" for which the individual agencies were created.

Industry and business, especially, deserve relief from repeated solicitations and the federated idea appeals to them. In general solicitation, the idea of federation is still in the experimental stage.

First results from federated campaigns have

been quite successful in the amount of money raised. The continuance of this rate of giving will probably diminish as the newness wears off and as people, particularly employees, come to look upon these gifts as just another deduction in their pay checks. If the purpose to the giver becomes only the raising of money, he will either quit giving or insist that the government take over. He needs a cause that appeals to his sense of responsibility and voluntary interest.

There is also the question of saving manpower, which the federalizers point to as very significant, in the "one appeal." But do we wish to save this manpower if there is actually something noble and therapeutically good for the people who participate in these tasks? Maybe we need even more causes for people to interest themselves in.

#### SUMMARY

Voluntary agencies provide a natural outlet for the expression of charitableness and concern, which is a part of the character of the democratic spirit of Americans. They manifest to the highest degree the philosophy of the free enterprise system.

Amalgamation of health agencies might make operation more efficient and economical and equalize support and attention among various problems, but would defeat in great measure the very freedom that we are fighting to maintain in our society and particularly in the field of medicine. It would reduce the stimulation and opportunity for public service which should be increased rather than decreased. The logical end could well be bureaucracy and governmental control.

Federated systems for solicitation bring relief from repeated appeals for money. They are especially attractive to organized business and industry. "All of your 'askits' in one basket" has appeal at the present time, but will probably slide on the curve of diminishing returns since it hampers free choice of interest and carries the seed of bureaucracy.



## EMERGENCY COUNCIL ON CIVIL DEFENSE

GLEN WARD LEE, M.D.

*Richmond*

A MEETING of the Emergency Council on Civil Defense was held in Chicago on November 9 and 10, 1951. The meeting was sponsored jointly by the A.M.A., the American Hospital Association, and Association of State and Territorial Health Officers.

Dr. James C. Sargent, Chairman, Council on National Emergency Medical Service, A.M.A., chaired the meeting. Reports were given as to interest, phase, planning and organization for Civil Defense by each of the sponsoring organizations, plus the American Dental Association and other related professions.

Progress reports and recommendations for state planning, organization and operation in the various medical phases of Civil Defense were made by representatives of various departments of the Federal Civil Defense Administration.

To me the most important paper was one by Mr. Anthony W. Eckert, Hospital Administrator, Perth Amboy, New Jersey; which reported how the Civil Defense and Emergency Disaster Planning enabled his 200 bed hospital to handle casualties from a munitions explosion, which killed 31 persons and injured approximately 350, and ten months later casualties from the Pennsylvania train wreck, which killed 85 persons and injured over 500.

A big problem for me this past year has been how to plan for the 50,000 estimated casualties who would require hospitalization as a result of the atomic bombing of a single target city in Indiana. We have only 11,000 beds in all the general hospitals in the state.

The following take-off on Mr. Eckert's plan, when put into effect by every general hospital outside a target area, will go far toward completing a state Civil Defense program.

Every general hospital in the state should have an Emergency Disaster and Civil Defense plan.

First, arrangements must be made to evacuate as many beds as possible in case of an emergency or disaster. This can be planned for by agreements from ladies of hospital guilds, Gray Ladies or other similar groups, to come to hospitals on call and to transport patients, in their cars, to the patient's own home; or, being unable to take the patient to his or her home because of circumstances there, then to take the patient to the guild member's home. This requires a system of classification of condition of patients in the hospital at all times, such as:

Class I—Ambulatory patients who could walk out of hospital by themselves.

Class II—Those who could walk with help.

Class III—Those who could be moved by ambulance or car.

Class IV—Those whose conditions necessitate their retention in the hospital.

By this means it should be possible to evacuate 60 percent of the beds in any general hospital, exclusive of pediatrics and obstetrics, within one hour after the emergency plan is called into operation.

The superintendent of the hospital or the chief of staff should declare the emergency and notify the switchboard operator to call a "captain" or designated alternate of the guild, or other, and notify her of the emergency. She in turn would call several lieutenants who would have lists to call. This then needs only ONE call from the hospital switchboard, which will be otherwise busy, to put into operation.

A similar single call to the "captain" of an organized Women's Auxiliary results in notification of all physicians to report to the hospital for emergency duty. Similar single calls will call for a police guard on the hospital. No one should be admitted without an identification card showing that they have an Emergency Disaster or Civil Defense assignment in the hos-



pital. Other calls to be similarly made are to the Graduate Nurses Association; orderlies and aids; hospital maintenance, and housekeeping department personnel.

The chief of staff will preferably be a doctor with experience in Army Field or Evacuation Hospitals.

The members of the Staff will be divided into:

- Surgical Section —Includes Anesthesia & Orthopedics
- Burn Section —Includes Shock & Splints
- Shock Section —Blood-Plasma & Triage
- Laboratory Section—Draw Blood et cetera.
- Sorting Section —Also Triage

Each member of the staff will report in the hospital to a designated area for his section and will stay there until ordered elsewhere by the chief of staff or released if there is nothing for his section to do.

There must also be personnel assigned to cover pediatrics, obstetrics and minimal medical coverage to the local population. It is also wise for some personnel to be assigned to first aid teams to go to the site of a disaster, should need arise.

All nurses on staff duty as well as all personnel under the hospital superintendent will report to the hospital on emergency call for their assigned duties, and will continue there until released or reassigned by the superintendent.

The superintendent of nurses will assign and control student nurses and plan to evacuate beds in nurses home, should there be need. Student nurses could temporarily be housed in doctor's homes et cetera.

The operation of ambulances to bring patients from the scene of the disaster to the hospital should be left to the undertakers, Red Cross et cetera, but their plans should be coordinated with the Emergency Hospital Plan. Also, plans for morgue service must be made.

Public Relations and reporting will be a big problem in any major disaster. Plans should be made to handle this outside of the hospital, since all hospital personnel will be busy. This could be handled through appointed representatives from the local press.

Hospital superintendents have had training and experience in this sort of planning; they are important in the organization. Call on them to cooperate and assist in your planning and utilize their advice and assistance. After plans for a maximum medical emergency mobilization have been made, plans should be considered for dividing the sections into 12 hour shifts so that a sustained effort could be maintained.

Dry runs or practice drills must be made until the "bugs" have been found and worked out. They should be repeated until assured of having personnel and equipment at hand, on call, to operate efficiently. Drills should then be run through often enough to acquaint new personnel with their duties and assignments. It is important, for example, that keys are available in the hospital to every department and storage facility at all times.

The above portion of the plan is essential for all general hospitals at all times. Not one minute of time spent on it could ever be considered as wasted. Any of us could have a train wreck or factory explosion at our doorstep at any time.

To expand this plan for civil defense, sites for auxiliary hospitals in relative proximity to existing general hospitals should be selected and tentative plans and arrangements for their utilization made; for example: the gyms and field houses of schools and colleges, churches, Y.M.'s and Y.W.'s, country clubs, state parks et cetera.

Each household could be requested to get together a parcel containing a quilt, a blanket, 2 sheets, a pillow and pillow case, towel and wash cloth, and bar of soap. This should be wrapped in heavy paper and twine and clearly marked, "For Civil Defense." Every member of the household should know where and what it is. Those having such a package always prepared and kept clean and ready could be listed or identified by civil defense stickers in their windows. The packets could then be collected by prearrangement with moving vans, trucks from furniture stores, and delivered to auxiliary hospitals, should the need ever arise to make pallet beds for medical emergency casualties.

After treatment at existing general hospitals, patients could then be moved to auxiliary hospitals for after care and treatment.

Plans must of course be made for staffing the auxiliary hospitals with graduate nurses from the community who are not assigned to

the general hospitals, supplemented by lay First Aid Workers, Red Cross et cetera. One or two doctors should be assigned to each auxiliary hospital. Feeding should be planned by Emergency Welfare. The general supervision, records, et cetera, will be controlled through the existing general hospital.

This is not an attempt to usurp the prerogatives of Red Cross Emergency Disaster programs. Rather, I believe all groups and plans should be merged so that organized medicine,

with the hospital's help, is ready to handle any emergency, no matter what its kind or size.

This plan requires civil defense operational plans to move patients from the site of disaster to outlying hospitals and their staffs in the state, but it would seem doctors could do a better job working in accustomed surroundings with accustomed equipment than with field first aid equipment in improvised aid stations and hospitals, though some of the latter will be necessary.

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## PUBLIC RELATIONS CONFERENCE

EARL W. MERICLE, M.D.\*

*Indianapolis*

**T**HE fourth Annual Medical Public Relations Conference of the A.M.A. was held December 2 and 3, 1951 at the Hotel Biltmore in Los Angeles. Toastmaster of the opening luncheon was Doctor John W. Cline, president of the American Medical Association. Doctor Cline remarked that public relations has brought help to the doctors of the country in the last four years and must continue at all levels. He impressed the audience with the importance of this meeting.

**Louis H. Bauer, M.D.**

The keynote address was given by Louis H. Bauer, M.D., president-elect of the American Medical Association. The title of his address was "Working Together in '52." Doctor Bauer remarked that medicine works with other groups, that it must unify itself generally throughout the country, and the county societies must be vitalized. Doctors, he said, must learn to work together or standards of medical care will fall. It was his opinion that politicians take over if doctors do not take care of the problems themselves. He remarked that members must take interest—they can't just complain, but must work for the common good, and he inferred that

this went on at all levels, not just in the county societies. He remarked about why the A.M.A. dues were not paid 100 percent. Some were excused because of old age. Some were out of sympathy with A.M.A. policies. Many doctors were uninformed and the larger group was ungrateful for what had been done for them by the A.M.A. It was Doctor Bauer's opinion that education, hospitals and freedom in medicine all were due to A.M.A. activities in the past. He remarked that the A.M.A. only pursues majority opinions if it knows what they are. If change is needed then we should accept the responsibility and fight for the changes as needed. He inferred that our country is in bad shape because people are disinterested in the government, and for this reason doctors are more important as citizens because we have been awakened in the past to what the situation really is. Doctor Bauer's idea is that the citizens should depend on themselves, not on the government. He stated further that nothing is free, certainly not government. He felt that we are ruled now by administrative law and that our leaders, sometimes, want us to become even more socialistic than we are, and socialism has never worked. Still, we are moving toward it. If we continue in this direction our end result will be that we have traded freedom for government subsidy.

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\* Chairman, Public Relations Committee, Indiana State Medical Association.



Doctor Bauer remarked that only 40 percent of the voters voted in 1948 and that all citizens must be made aware of their duty in the support of all American institutions, namely, government, in the future. American medicine must lead the way to Americanism and get support from everyone who works for Americanism. The tide can be turned in '52 away from socialism if we will all go to work and do what we can to help.

### Ernest Dichter, Ph.D.

The first panel of this meeting occurred at 2:30 in the afternoon. The chairman was Doctor Gunnar Gundersen of La Crosse, Wisconsin, and the subject of this panel was "What the People Think." The first paper was read by Ernest Dichter, a Ph.D., of New York, who is a psychological consultant and has done some work in Alameda County, California. It was on this work that he made his report. This speaker, I believe, was a Freudian trained man as he used the analytic concepts frequently in his talk. He began by pointing out that flying was not used by people because they feared death but rather that they feared posthumous embarrassment. He next pointed out that a book-of-the-month club promised literacy and people thought that all they needed to do was send in the coupon. Later they learned they had to read the books. The books kept coming and piling up and up, and the book-of-the-month club was about to become a failure because of this. By some clever advertising they were able to circle important people with their books-of-the-month piled high and this brought about the idea to the rank and file that they too were like the others, and it was difficult for all to get their work done and their books read. This saved the day for the book-of-the-month people.

He discussed the doctor-patient relationship and he remarked that cutting fees in half would not solve the present problem in this relationship. This man's concept was that the doctor is an integral part of the culture in which he lives and that changes are going on in this culture, and that leaders are needed in this culture. The doctor was a leader until he lost it but the need still exists. The doctor now feels that he is driven and not the driver, and the doctors have sold their birthright to shrug their shoulders and say "It's hopeless to try to do anything about it." This essayist believed that there was no ill will on the part of the patients towards doctors,

but rather that a revolution was going on in our country and the modern doctor is out of tune with the times. He discussed five aspects of the doctor's personality. First is the conflict of idealism and realism going on in the doctor. The doctor is definitely caught in this trouble. During medical school something happens to the doctor. He discovers the hard realities of life, and this leads to conflict between idealism and bread-winning, and causes anxiety to the physician and will cause him to defend medicine at all costs. The patient complains that the idealistic doctor is gone. He is looking for a personal physician and Joe Doaks wants his personal physician the same as President Truman has his. The patient also resents belonging to one doctor. The patient wants to participate, in a word, and this is true in all fields of the humanities, not only medicine. The psychologist believed that the doctors need to tell their patients more about their illnesses.

The second characteristic is that most doctors are rugged individualists. They were hard put to work their way up to their present status, and find it difficult to engage in team work. The doctor must accept his place in caring for the weak and accept his responsibility in that measure. If the doctor despises the weak he is only accepted when needed. The doctor must do more than make the patient well. He must follow-up on his treatment. The patient resents no follow-up on treatment.

The third characteristic is a sense of power which the doctor utilizes which leads him to decide when to tell a patient to do something. This sense of power is now being challenged by the patients and is even more challenged by modern journalism. The patients no longer accept the power of the doctor. They want to know "why." In other words, the patients are now more intelligent and more mature, and not ready to accept the power of the doctor, and the doctors, of course, resent this.

A fourth characteristic mentioned in regard to medicine by this man was the high cost of medical care. Most doctors admit that costs are high. The patient feels that he is exposed to biological blackmail. The doctors ask, "How much is your life worth to you?" to answer this complaint. The patient wants a constant fee schedule. The most common complaint is no explanation of the medical fee and the patient blames the doctor for that. The patients believe

that doctors make too much money and too soon after starting into practice drive too many Cadillacs.

A fifth aspect of this relationship is a desire for affection on the part of both the doctor and the patient. The doctor must be loved and admired. If not, he is hurt. The patients want guidance and direction and continuous care. The doctors must know that they can do the job, too. The doctor should state his right to the fee to the patient, and the patient must accept the doctor's right to charge. But generally, this man feels that the doctors must equalize fees. He felt that the medical society must be ready to mix in society again. They should recognize that the world is changing and be ready to change with it, and integrate themselves into the changes. Psychologically, the doctor is the father, the patient is the son. The son is grown up and now talks back to the father. Both must mature to the point where this relationship can go on.

#### **Edgar A. Schuler, Ph.D.**

The next report of this conference was by Edgar A. Schuler, Ph.D., Detroit, Department of Sociology, Wayne University, who reported on a survey of the Toledo area. This survey was financed by the Toledo Academy of Medicine, the Health Foundation of New York City, and Wayne University. The Foundation study was made for better health measures. The survey was made by two sociologists and one political scientist. They studied five phases of population; 600 families, representative samples of 50 doctors, 50 leaders in the area, a sample of complaints investigated, and the fifth part was the organization of the public relations division of the Academy. The study he discussed was made in the postwar time when health procedures by the unions were being advocated, the doctors were coming back from the services, and newspaper articles were criticizing doctors for bad practices.

The Public Relations Committee of this society established a Grievance Committee and began advertising their own virtues. They established a telephone answering service, complaints were processed quickly, the Grievance Committee functioned adequately and enough power was given to the committee and the society to punish any offenders. They learned in their advertising campaign that newspaper advertising did not afford means of reaching the leaders in the com-

munity, and a study of 50 leaders of that community indicated certain things. Many leaders were critical of certain practices: excessive fees, unnecessary surgery, the cost of medicine too great. Some of the leaders favored compulsory health insurance.

In a study of the doctors they learned that the doctors were reacting to the public relations program in this community. They approved of the program. Nine out of ten doctors approved it and all felt that emergency medical service was the greatest problem the community had. Most people felt that a sliding scale of fees was not good. The doctors' chief complaint was the shortage of hospital beds and the shortage of medical personnel to aid in the treatment of patients.

In the study of the 600 families it was learned that only 23 percent of the people read newspaper ads. Twelve percent had trouble in getting a doctor. One percent had resorted to the Academy advertising to locate a doctor. Three out of four people had a family doctor. Thirty percent thought more doctors were needed. A summary of the study revealed that most people get their own doctor and have their own doctor. All people interviewed thought that doctors should lead in community life. Referring to costs, 43 percent said that costs were high, 4 percent said too high; 84 percent had insurance of some kind: 62 percent for surgery and 22 for other medical services. Less than one person in 20 was dissatisfied with medicine. In conclusion, they felt in this study that the most serious problems facing medicine today are the high cost of medicine and shortage of hospital beds and medical personnel. This speaker was rather pessimistic. He thought that the socializing influence in the country due to urbanization, industrialization, specialization, hospital needs, shortage of doctors, and rising standards of living might make it almost impossible to stop the trend toward socialism now.

#### **Lawrence W. Rember**

The next paper on this panel was by Lawrence W. Rember, Chicago, Director of Field Service, Department of Public Relations, American Medical Association, entitled "An Urban-Rural Opinion Test Tube." Decatur, Illinois, (Macon County) was chosen as it was thought to be the most typically American county and city in the United States. Thirty basic questions



were asked of many people regarding doctors and medical societies, the availability of care, the cost, out-of-town medical care, prepayment plans, attitudes toward doctors and attitudes toward the A.M.A. The following facts were revealed in this study: 91 percent of the people had a family doctor; 89 percent had seen a doctor in the past year; 9 percent of people past 40 were more apt to see a doctor than people under 40; 9 percent of the people had seen a specialist, the specialist was seen 39 percent of the time on the recommendation of another doctor, and 36 percent of the time on the recommendation of others; 88 percent of the families could get a doctor to make a call when needed; 4 percent said sometimes; 69 percent of the people said the doctors responded to a home call quickly; 7 percent said there was too long a delay.

In regard to costs, twice as many thought surgical services high as thought medical costs were high. In the breakdown of this, the house call was thought to be high by 12 percent of the people; office call was thought to be high by 12 percent of the people; 29 percent of the people thought surgical expenses too high and 44 percent of people thought hospital expenses too high. One out of fourteen had never been in a hospital. As regards the quality of care, surgical care was regarded as excellent twice as often as medical, hospital and nursing service was regarded as excellent. Surgery was regarded as poor by 4 percent, while medicine was not regarded poor by anyone. Hospital and nursing care received twice the number of complaints. The breakdown: 21 percent thought hospital care excellent, 51 thought it good, 21 thought it fair and 8 percent thought it poor. Medicine: 38 percent thought it excellent, 53 percent good, and 9 percent fair. Surgery: 51 percent thought it excellent, 38 percent good, 7 percent fair, and 4 percent poor. Nursing service: 22 percent thought it excellent, 53 percent good, 21 fair, and 4 percent poor. Ninety-one percent of the people thought that their doctor had an interest in them.

Regarding prepaid insurance, 81 percent of the families had insurance. Eighty-four percent of policyholders were satisfied. Seventy-two percent of the people thought that the doctors were civic minded, 22 percent said moderately, 6 percent said that they were not civic minded at all. Ninety-four percent liked doctors as people.

Twenty-nine percent would change doctors to make them less independent, less vague, less hurried and less cold. Sixty-five percent of the people in Macon County could not name a single interest of the medical society in that county. Eighty-nine percent of the people regarded the medical society as OK, eight percent regarded it unfavorably.

In regard to the American Medical Association, 82 percent had heard about it, 82 percent liked it, 15 percent were unfavorable to it, and 3 percent were neutral.

This study is interesting when placed in ordinary figures. At least, if we knew that 4 percent of our population did not like doctors, translated to Marion County, that would mean 20,000 people in this county do not like doctors. That is a rather formidable amount.

#### **Cyrus W. Anderson, M.D.**

One of the papers on December 3 was by Dr. Cyrus W. Anderson, Denver, Chairman, Board of Trustees, Colorado Medical Society and was entitled, "Explaining Those 'Other' Medical Expenses." Doctor Anderson remarked that physicians' fees have risen only a small amount in many years, but they are credited with all the sickness fees that people pay now.

This doctor stated that to help in the fight against socialized medicine it was necessary for the profession to have better public relations, get off the perch and go to work, cooperate with the press and radio, reduce the number of unnecessary procedures done in laboratories, tell why expensive drugs are used, discuss fees, itemize bills, and take the time to discuss fees with the patients.

#### **Stanley R. Truman, M.D.**

The next speaker was Dr. Stanley R. Truman, Ventura, California, Past President of the American Academy of General Practice. His title was "Time is Money for Your Patient Too." This speaker very dramatically came to the podium and stood there at least two minutes before he uttered a sound. His opening remark was, "Waiting. It's boring, isn't it?" He said that patients resent waiting on the doctor and that the doctor and his secretary should use every available means to cut down on the waiting that patients do in doctors' offices, and try to make the office as comfortable and pleasant for

the patient as possible. This waiting brings about resentment. The doctor must attend to scheduling, improve the physical setup of the office and be concerned about the patient's time. The secretary must be cooperative and not indifferent, schedule appointments realistically as to time. On the telephone the secretary and the doctor are to make the caller feel that the best thing is being worked out for the patient. If sincere, it works better.

If the doctor is late, give the patient the reason, and make the patient's presence in the office an important matter.

#### **Earl W. Mericle, M.D.**

My talk was on the problem of "The Patient and His Big Bills." Various means that doctors have evolved for helping patients with big bills throughout the past were discussed. This included prepayment plans, budgeting, finance companies, and insurance. I believe that catastrophic sickness insurance is perhaps the best answer to the problem. The type written in California now covers 22 major illnesses and will cover a large number of the illnesses which we see here which will become catastrophic to the patient. Adequate voluntary insurance seems to be the best answer to this problem.

#### **Joseph F. Donovan**

The next paper was by Joseph F. Donovan, San Jose, California, Executive Secretary, Santa Clara County Medical Society. This gentleman had an experience which was unique. The title of his paper was, "The 'Regardless of Ability to Pay' Idea." At the start of Governor Warren's campaign for compulsory health insurance in California, this group of doctors decided that they must band together in an effort to counteract the publicity that was coming against the doctors there. They inserted advertisements in the papers that they would take care of any patient regardless of his ability to pay—that this was no issue with the doctors. They had a lot of fear and trembling as the ad went to press the first day, and strangely enough the number of requests for free medical care which came to these doctors was so slight that they amounted to practically nothing. This certainly goes a long way to prove that the American public is taken care of pretty well.

#### **Leo E. Brown**

The final panel was entitled, "Where Do We Go From Here?" The first essayist was Leo E. Brown, Chicago, Director of Public Relations, the A.M.A.'s 1952 PR program. Mr. Brown brought out the fact that the A.M.A.'s public relation program is now on the move and that it can't rest on its laurels, that all must share in this responsibility. He also brought out the fact that a horse can't pull while it is kicking, and a horse can't kick while it's pulling, meaning that all components of American medicine should pull together.

There are two phases of this public relations activity. One is the internal phase within the profession. The other is the external phase, which is directed toward the attitude of others toward the profession. Our objectives are to gain the support of the people by informing them of the accomplishments and what our aims are, to improve the doctor-patient relationship, encourage state and county societies to go along with public relations programs at any cost. Some of the things which will be done will be to utilize the public relations releases to newspapers and other mediums of information. Feature articles will be written. Continuing brochures will be supplied to doctors and the public concerning A.M.A. activities. The A.M.A. wants the doctors to distribute the material to various groups. The A.M.A. now clears many articles for magazine publication. In other words, articles written about medicine are submitted to the A.M.A. for approval before they are published.

The A.M.A. next year will play host to the American Legion, Farm Bureau, P.T.A., the Bar Association, the A. F. of L. and C. I. O., and other groups who wish to come to Chicago to meet with them. They will supply slides and movies and information to groups and publications. They will supply convention bulletins, the Secretary's Letter and the PR Doctor, to the profession.

Down at the grass roots level, Leo Brown believes that the grievance committees, emergency medical care service, cleaning up our own ranks, becoming civic minded, supporting rural health, supporting school and civil defense programs, and continuing the education program, will all help to defeat socialized medicine in 1952.



## FACTS ABOUT A.M.A. DUES FOR 1952

THE following information on membership dues for the American Medical Association for 1952 has been compiled by the office of the Secretary of the American Medical Association.

1. American Medical Association membership dues for 1952 are \$25.

2. Fellowship dues for 1952 have been abolished.

3. American Medical Association membership dues are levied on "active" members of the Association. A member of a constituent association who holds the degree of Doctor of Medicine or Bachelor of Medicine and is entitled to exercise the rights of active membership in his constituent association, including the right to vote and hold office as determined by his constituent association, and has paid his American Medical Association dues, subject to the provisions of the By-Laws, is an "active" member of the Association.

4. American Medical Association membership dues are payable through the component county medical society or the constituent state or territorial medical association, depending on the method adopted locally.

5. Commissioned medical officers of the United States Army, the United States Navy, the United States Air Force or the United States Public Health Service, who have been nominated by the Surgeons General of the respective services, and the permanent medical officers of the Veterans Administration and the Indian Service, who have been nominated by their Chief Medical Directors, may become Service Fellows on approval of the Judicial Council. Service Fellows need not be members of the component county or constituent state or territorial associations or the American Medical Association. They do not receive any publication of the American Medical Association except by personal subscription. If a local medical society regulation permits, a Service Fellow may elect to become an active member of a component and constituent association and the American Medical Association, in which case he would pay the same membership dues as any other ac-

tive member and receive a subscription to *The Journal of the American Medical Association*.

6. An active member of the American Medical Association may be excused from the payment of American Medical Association membership dues when it is deemed advisable by the Board of Trustees, provided that he is partially or wholly excused from the payment of dues by his component society and constituent association.

The following may be excused in accordance with this provision: (a) members for whom the payment of dues would constitute a financial hardship as determined by their local medical societies; (b) members in actual training but not more than five years after graduation from medical school; (c) members who have retired from active practice; (d) members who have reached the age of 70, on request, and starting January 1 following the 70th birthday, and (e) members who are called to active duty with the armed forces (exemption begins July 1 or January 1 following entrance on active duty). The last two categories are excused from A.M.A. dues regardless of local dues exemptions.

\*7. Active members of the American Medical Association are not excused from the payment of American Medical Association membership dues by virtue of their classification by their local societies as "honorary" members or because they are excused from the payment of local and state dues. Active members may be excused from the payment of American Medical Association membership dues only under the provision described in paragraph 6 above.

8. American Medical Association membership dues include subscription to *The Journal of the American Medical Association*. Active members of the Association who are excused from the payment of dues will not receive THE JOURNAL except by personal subscription at the regular subscription rate of \$15 a year.

9. Members may substitute one of the special journals published by the Association for THE JOURNAL to which they are entitled as members.

10. A member of the American Medical Association who joins the Association on or after July 1 will pay membership dues for that year of \$12.50 instead of the full \$25 membership dues.

11. An active member is delinquent if his dues are not paid by June 1 of the year for which dues are prescribed and shall forfeit his active membership in the American Medical Association if he fails to pay the delinquent dues within thirty days after the notice of his delinquency has been mailed by the Secretary of the American Medical Association to his last known address.

12. Members of the American Medical Association who have been dropped from the Membership Roll for nonpayment of annual dues cannot be reinstated until such indebtedness has been discharged, but such indebtedness shall apply only to the one year of delinquency.

13. The apportionment of delegates from each constituent association shall be one delegate for each thousand (1,000), or fraction thereof, *active members of the American Medical Association* as recorded in the office of the Secretary of the American Medical Association on December 1 of each year.

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## Official Call to the House of Delegates

### Interim Meeting

The interim meeting of the House of Delegates of the Indiana State Medical Association will be held on Sunday, April 27, 1952, at 10:00 a.m., (DST) at the Claypool Hotel, Indianapolis.

The House of Delegates will be constituted as follows: Marion County, seventeen delegates; Lake County, six delegates; Allen County, four delegates; St. Joseph County, four delegates; Vanderburgh County, four delegates; Delaware-Blackford, three delegates; Bartholomew-Brown, Daviess-Martin, Dearborn-Ohio, Elkhart, Fayette-Franklin, Fountain-Warren, Jasper-Newton, Madison, Owen-Monroe, Parke-Vermillion, Tippecanoe, Vigo and Wayne-Union County Societies, each two delegates; the other sixty-three county societies, each one delegate; thirteen councilors; and the ex-presidents, namely: C. S. Bond, W. H. Stemm, E. M. Shanklin, Charles N. Combs, George R. Daniels, Charles E. Gillespie, F. S. Crockett, J. H. Weinstein, R. L. Sensenich, Herman M. Baker, Karl R. Rud-dell, A. M. Mitchell, M. A. Austin, Carl H. McCaskey, J. T. Oliphant, N. K. Forster, J. E. Ferrell, Floyd T. Romberger, Cleon A. Nafe, Augustus P. Hauss, C. S. Black, and Alfred Ellison; and ex-officio, the president, president-elect, executive secretary, and the treasurer of

the association, and the delegates to the American Medical Association, all without power to vote, except in case of a tie vote, when the president shall cast the deciding vote.

The House will convene promptly at 10:00 a.m. in the Assembly Room on the eighth floor of the Claypool Hotel, and the meeting will continue through luncheon in the Chateau Room of the Claypool.

The order of business will be as follows:

1. Call to order by the president.
2. Roll call and seating of qualified delegates.
3. Reading of the minutes of previous meetings.
4. Appointment of reference committees.
5. Report of the treasurer.
6. Report of chairman of the Council.
7. Reports of standing and special committees.
8. Unfinished business.
9. New business.

JAMES A. WAGGENER,  
*Executive Secretary*



# HOUSE OF DELEGATES

## INDIANA STATE MEDICAL ASSOCIATION

### INDIANAPOLIS, INDIANA

April 27, 1952

Delegate	Alternate	Delegate	Alternate
<b>ADAMS</b>		<b>ELKHART</b>	
James M. Burk, Decatur	Norman E. Bearer, Berne	Burton Kintner, Elkhart S. T. Miller, Elkhart	Jack Hannah, Wakarusa Leon Chandler, Millersburg
<b>ALLEN</b>		<b>FAYETTE-FRANKLIN</b>	
H. Vaughn Scott, Fort Wayne	H. G. Haffner, Fort Wayne	H. N. Smith, Brookville J. M. Lockhart, Connersville	Perry Seal, Brookville F. B. Mountain, Connersville
W. C. Wright, Fort Wayne	R. H. Stauffer, Fort Wayne	<b>FLOYD</b>	
Elmer C. Singer, Fort Wayne	Herbert M. Senseny, Fort Wayne	John M. Paris, New Albany	C. E. Briscoe, New Albany
M. E. Glock, Fort Wayne	Gerald H. Somers, Fort Wayne	<b>FOUNTAIN-WARREN</b>	
<b>BARTHOLOMEW-BROWN</b>		Lee Maris, Attica James Crain, Williamsport	Lowell Stephens, Covington Carl Nelson, West Lebanon
L. F. Beggs, Columbus K. D. Schneider, Nashville	J. E. Dudding, Hope	<b>FULTON</b>	
<b>BENTON</b>		A. E. Stinson, Rochester	John Glackman, Rochester
V. L. Turley, Fowler	Charles Smith, Otterbein	<b>GIBSON</b>	
<b>BOONE</b>		Virgil McCarty Princeton	H. G. Petitjean, Haubstadt
Harvey D. Lovett, Whitestown	Clarence Kern, Lebanon	<b>GRANT</b>	
<b>CARROLL</b>		Max Long, Marion	J. P. Powell, Marion
Max Adams, Flora	Thomas C. Brown, Delphi	<b>GREENE</b>	
<b>CASS</b>		John Woner, Linton	Asa Fender, Worthington
E. B. Jewell, Logansport	John Davis, Logansport	<b>HAMILTON</b>	
<b>CLARK</b>		John S. Hash, Noblesville	Sam Campbell, Noblesville
Joel Carney, Jeffersonville	William Clark, Jeffersonville	<b>HANCOCK</b>	
<b>CLAY</b>		J. L. Allen, Greenfield	R. E. Kinneman, Greenfield
John M. Palm, Brazil	Charles Moon, Centerpoint	<b>HARRISON-CRAWFORD</b>	
<b>CLINTON</b>		<b>HENDRICKS</b>	
Frank Beardsley, Frankfort	Robert Hedgecock, Frankfort	O. T. Scamahorn, Pittsboro	J. C. Stafford, Plainfield
<b>DAVIESS-MARTIN</b>		<b>HENRY</b>	
Robert Rang, Washington	Arthur Blazey, Washington	W. M. Stout, New Castle	L. C. Marshall, Mt. Summit
<b>DEARBORN-OHIO</b>		<b>HOWARD</b>	
Gordon S. Fessler, Rising Sun	Charles N. Manley, Rising Sun	Richard P. Good, Kokomo	Robert Evans, Russiaville
J. K. Jackson, Aurora	M. J. McNeely, Dillsboro	<b>HUNTINGTON</b>	
<b>DECATUR</b>		G. M. Nie, Huntington	Thomas James, Huntington
<b>DEKALB</b>		<b>JACKSON</b>	
R. P. Reynolds, Garrett	F. B. Kantzer, Butler	Jack E. Shields, Brownstown	W. H. Shortridge, Seymour
<b>DELAWARE-BLACKFORD</b>		<b>JASPER-NEWTON</b>	
Kemper Venis, Muncie Clay Ball, Muncie Dean Jackson, Hartford City		W. G. Pippenger, Brook Frank G. Sink, Remington	
<b>DUBOIS</b>			
M. C. Heck, Jasper	C. H. Klammer, Jasper		

Delegate	Alternate	Delegate	Alternate
<b>JAY</b>		<b>MIAMI</b>	
<b>JEFFERSON</b>			
Robert O. Zink, Madison	S. A. Whitsitt, Madison	S. D. Malouf, Peru	E. E. Shrock, Amboy
<b>JENNINGS</b>		<b>MONTGOMERY</b>	
D. W. Matthews, North Vernon	B. W. Thayer, North Vernon	J. M. Kirtley, Crawfordsville	F. N. Daugherty, Crawfordsville
<b>JOHNSON</b>		<b>MORGAN</b>	
O. A. Province, Franklin	Harry Murphy, Franklin	<b>NOBLE</b>	
			Robert Bryan, Kendallville
<b>KNOX</b>		<b>ORANGE</b>	
Paul Arbogast, Vincennes	Herbert O. Chattin, Vincennes	<b>OWEN-MONROE</b>	
<b>KOSCIUSKO</b>		William C. Reed, Bloomington	R. E. Buckingham, Bloomington
Winton Thomas, Warsaw		Oran E. Kay, Spencer	C. E. Stouder, Gosport
<b>LA GRANGE</b>		<b>PARKE-VERMILLION</b>	
<b>LAKE</b>			
Harry R. Stimson, Gary	Michael Shellhouse, Gary	W. D. Britton, Montezuma	R. S. Bloomer, Rockville
Ray Elledge, Hammond	F. F. Premuda, Hammond	Paul Casebeer, Clinton	Fred Evans, Clinton
R. J. Modjeski, Hammond	O. L. Marks, East Chicago		
J. P. Vye, Gary	R. A. Elliott, Gary		
S. J. Petronella, East Chicago	E. L. Schaible, Gary		
W. R. Troutwine, Crown Point	J. P. Birdzell, Crown Point		
<b>LAPORTE</b>		<b>PERRY</b>	
G. O. Larson, LaPorte	V. F. Kling, Michigan City	D. L. Lashley, Tell City	N. A. James, Tell City
<b>LAWRENCE</b>		<b>PIKE</b>	
Donald M. Kerr, Bedford	L. E. Benham, Bedford	M. H. Omstead, Petersburg	J. L. Higgins, Petersburg
<b>MADISON</b>		<b>PORTER</b>	
P. T. Lamey, Anderson	J. L. Doenges, Anderson	Ralph C. Eades, Valparaiso	John R. Frank, Valparaiso
G. B. Wilder, Anderson	Ralph Ploughe, Elwood		
<b>MARION</b>		<b>POSEY</b>	
Howard W. Beaver, Indianapolis	O. H. Bakemeier, Indianapolis	Wm. B. Challman, Mount Vernon	Paul Boren, Poseyville
Lester D. Bibler, Indianapolis	Edward F. Bloemker, Indianapolis		
Floyd A. Boyer, Indianapolis	Wendell E. Brown, Indianapolis		
James W. Denny, Indianapolis	Paul K. Cullen, Indianapolis		
Ralph V. Everly, Indianapolis	Forrest L. Denny, Indianapolis		
W. D. Gatch, Indianapolis	W. Stanley Garner, Indianapolis		
Lester H. Hoyt, Indianapolis	Jacob E. Gillespie, Indianapolis		
Clifford H. Jinks, Indianapolis	Thomas A. Hanna, Indianapolis		
Maurice V. Kahler, Indianapolis	Jerome E. Holman, Sr., Indianapolis		
D. S. Megenhardt, Indianapolis	George F. Lawler, Indianapolis		
Earl W. Mericle, Indianapolis	B. J. Matthews, Indianapolis		
Paul Merrell, Indianapolis	Robert W. McTurnan, Indianapolis		
T. V. Petranoff, Indianapolis	William H. Norman, Indianapolis		
Bernard D. Rosenak, Indianapolis	Morris B. Paynter, Southport		
Ray Tharpe, Indianapolis	Philip B. Reed, Indianapolis		
Kenneth E. Thornburg, Indianapolis	John B. Westfall, Indianapolis		
William B. Lybrook, Indianapolis	Don J. Wolfram, Indianapolis		
<b>MARSHALL</b>		<b>ST. JOSEPH</b>	
A. A. Thompson, Tyner	M. O. Klinger, Plymouth	D. D. Stiver, South Bend	George Gates, South Bend
		A. S. Giordano, South Bend	J. F. Murphy, South Bend
		M. I. Hewitt, South Bend	Donald Grillo, South Bend
		F. R. N. Carter, South Bend	C. S. Culbertson, South Bend
		<b>SCOTT</b>	
		Floyd S. Napper, Scottsburg	Marvin L. McClain, Scottsburg
		<b>SHELBY</b>	
		Paul R. Tindall, Shelbyville	R. F. Whitcomb, Shelbyville
		<b>SPENCER</b>	
		John Barrow, Dale	John C. Giackman, Jr., Rockport



Delegate	Alternate	Delegate	Alternate
<b>STARKE STEUBEN</b>		<b>VIGO</b>	
Donald G. Mason, Angola	James A. Alford, Hamilton	E. O. Nay, Terre Haute	A. W. Cavins, Terre Haute
		Hubert T. Goodman, Terre Haute	Wm. C. Kunkler, Terre Haute
<b>SULLIVAN</b>		<b>WABASH</b>	
C. F. Briggs, Sullivan	C. E. Whipps, Carlisle	Arthur J. Steffen, Wabash	O. G. Brubaker, N. Manchester
<b>SWITZERLAND TIPPECANOE</b>		<b>WARRICK WASHINGTON</b>	
Gordon A. Thomas, Lafayette	W. W. Washburn, Lafayette	I. E. Huckleberry, Salem	
Raymond Calvert Lafayette	Harry E. Klepinger, Lafayette	<b>WAYNE-UNION</b>	
		Will Thompson, Liberty	Frank Lewis, Liberty
		Harry P. Ross, Richmond	Glen W. Lee, Richmond
<b>TIPTON</b>		<b>WELLS</b>	
A. E. Stouder, Kempton	Meredith Gossard, Tipton	Truman E. Caylor, Bluffton	Thomas O. Dorrance, Bluffton
<b>VANDEBURGH</b>		<b>WHITE</b>	
Minor Miller, Evansville	John Alexander, Evansville	N. A. Hibner, Monticello	J. P. Galbreth, Burnettsville
Henry J. Rusche, Evansville	Daniel C. Tweedall, Evansville	<b>WHITLEY</b>	
Paul D. Crimm, Evansville	Robert A. Royster, Evansville	Paul Garber, South Whitley	Otto Lehmberg, Columbia City
C. C. Herzer, Evansville	Albert S. Ritz, Evansville		

## REFERENCE COMMITTEES—1952

### 1. Sections and Section Work:

Richard P. Good, Kokomo (Howard), chairman  
Clay A. Ball, Muncie (Delaware-Blackford)  
Truman E. Caylor, Bluffton (Wells)  
E. B. Jewell, Logansport (Cass)  
G. M. Nie, Huntington (Huntington)

### 2. Rules and Order of Business:

Joel T. Carney, Jeffersonville (Clark), chairman  
L. F. Beggs, Columbus (Bartholomew-Brown)  
A. E. Stinson, Rochester (Fulton)  
W. G. Pippenger, Brook (Jasper-Newton)  
John Palm, Brazil (Clay)

### 3. Medical Education and Hospitals:

Elmer C. Singer, Fort Wayne (Allen),  
chairman  
James W. Denny, Indianapolis (Marion)  
D. D. Stiver, South Bend (St. Joseph)  
Floyd S. Napper, Scottsburg (Scott)  
Donald G. Mason, Angola (Steuben)

### 4. Public Policy and Legislation:

Ralph Everly, Indianapolis (Marion), chairman  
Guy B. Ingwell, Knox (Starke)  
Paul A. Garber, South Whitley (Whitley)  
I. E. Huckleberry, Salem (Washington)  
Arthur J. Steffen, Wabash (Wabash)

### 5. Publicity:

G. B. Wilder, Anderson (Madison), chairman  
N. A. Hibner, Monticello (White)  
Hubert T. Goodman, Terre Haute (Vigo)  
W. M. Stout, New Castle (Henry)  
Paul Arbogast, Vincennes (Knox)

### 6. Hygiene and Public Health:

Minor Miller, Evansville (Vanderburgh),  
chairman  
J. M. Kirtley, Crawfordsville (Montgomery)  
Paul R. Tindall, Shelbyville (Shelby)

Jack Shields, Brownstown (Jackson)  
Robert O. Zink, Madison (Jefferson)

### 7. Amendments to Constitution and By-Laws:

Alfred Ellison, South Bend (St. Joseph),  
chairman  
Harry P. Ross, Richmond (Wayne-Union)  
Claude S. Black, Warren (Huntington)  
S. D. Malouf, Peru (Miami)  
Clifford H. Jinks, Indianapolis (Marion)

### 8. Reports of Officers:

W. R. Troutwine, Crown Point (Lake), chairman  
Max Adams, Flora (Carroll)  
Bernard D. Rosenak, Indianapolis (Marion)  
G. O. Larson, LaPorte (LaPorte)  
Donald M. Kerr, Bedford (Lawrence)

### 9. Committee on Credentials:

William E. Amy, Corydon (Harrison-  
Crawford), chairman  
Donald L. Lashley, Tell City (Perry)  
O. A. Province, Franklin (Johnson)  
Lester Hoyt, Indianapolis (Marion)  
O. T. Scamahorn, Pittsboro (Hendricks)

### 10. Committee on Miscellaneous Business:

John M. Paris, New Albany (Floyd), chairman  
S. T. Miller, Elkhart (Elkhart)  
J. L. Allen, Greenfield (Hancock)  
Earl W. Mericle, Indianapolis (Marion)  
Oran E. Kay, Spencer (Owen-Monroe)

### 11. Committee on Prepaid Medical Insurance:

Maurice V. Kahler, Indianapolis (Marion),  
chairman  
William C. Reed, Bloomington (Owen-Monroe)  
C. F. Briggs, Sullivan (Sullivan)  
A. E. Stouder, Kempton (Tipton)  
F. R. N. Carter, South Bend (St. Joseph)

# The Fourth Estate Looks At Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

## LOCAL DOCS DOCK THEMSELVES

If Allen County physicians are guilty of exploiting the medical assistance phase of the welfare program, then the medical welfare and relief cost board's work for the past 12 years is a mockery.

But the facts say otherwise.

In a series of articles Herbert R. Miller, of our editorial staff, has described how this 16-member board operates.

The public may be interested in how this series came to be published.

A recent *News-Sentinel* editorial, citing the \$6,525,835 spent last year to pay for medical care of Indiana's welfare clients, asked the question whether such medical costs had reached unreasonable levels.

The figure sounded high to the layman. A member of the Legislative Welfare Investigating Commission had said he was convinced "there is a goodly number of doctors who are exploiting the medical assistance phase of the welfare program." His commission is due to report its findings at the next session of the Legislature.

The editorial in question, without censure or praise, stated that in Allen County medical expenses connected with the welfare program cost the taxpayers \$193,202.

In response to that editorial the president of the Allen County Medical Society, for the first time as far as we know, called this newspaper's attention to the screening process to which all welfare and relief medical bills are subjected.

Because the project is already 12 years old, according to our informants, it seemed to us high time the public knew about it. For there is no doubting that many dollars are saved the beleaguered taxpayer when the doctors dock themselves. This is, from all appearances, a policing chore which other professions and businesses who do business with Government could take on with profit to the public and credit to themselves.

Just why the local medicos should have held their tongues for 12 years is not clear to us; but it probably stems to some ancient theory that the practitioner must in no way advertise his achievements. This is outside the orbit of any individual doctor's achievement. To us it doesn't make very good sense

or very good public relations to withhold information obviously in the public interest. The medical cost reviewing procedure belongs in that category.

But let us be clear on one thing. The very fact that the medical cost reviewing panel exists is proof of its need. With our representative present, one case was cited in which a surgeon's bill for \$200 was pared to \$100. In another, obviously a clerical error, a statement was sent for a prostate operation for a woman. There were many "adjustments" which, we trust, were not made to impress a visiting newspaperman.

Mr. Miller writes that the aggregate saving to the taxpayer is large.

The exact figures of real significance would be the total of bills submitted in a year and the total amounts pared in a year. This would be a graphic way to tell Allen County taxpayers the kind of protection they're getting through this splendid job of voluntary policing.

\* \* \*

Returning to the original problem of high medical costs, *state-wise*, *The News-Sentinel* is now prepared to suggest or support two definite and workable proposals which would tend to curb such costs:

1. Provide, by statute, if necessary, that public funds in exact amounts spent and names of doctors and dentists to whom they're paid be made a public record. This proposal is already in the thinking of the Legislative Welfare Investigating Commission. This newspaper endorsed it several days ago.

2. Establish and conduct voluntary medical and welfare cost review panels in *every county*. We are led by inference to believe the Allen County screening procedure is unique and somewhat rare. The Indiana State Medical Association recently urged county medical organizations to set up similar review boards. The rate at which such machinery goes into high gear in other counties will indicate how willing the profession, outside of our community, is to do its own policing.

\* \* \*

The Allen County Medical Society has earned the county's gratitude for taking the initiative on this problem, long ago. If other societies had shared this kind of thinking more generally, socialized medicine wouldn't be the threat it is today.

—Fort Wayne News-Sentinel



## News Notes

### MEAD JOHNSON AWARD

Five hospitals and five medical schools have been selected to nominate candidates for the Mead Johnson General Practice Scholarship awards offered by the American Academy of General Practice.

Stamford Hospital of Stamford, Connecticut, Methodist Hospital of Indianapolis, Crawford W. Long Memorial Hospital of Atlanta, Georgia, John Gaston Hospital of Memphis, Tennessee, and Dr. W. H. Groves Latter Day Saints Hospital of Salt Lake City, Utah, were chosen by the committee. These hospitals, representing all sections of the country, have submitted the names of interns to be candidates. From the total of 15 interns—three from each hospital—the Academy committee will select the five winners, who will receive \$1,000 scholarships each for one year's residency training in general medicine and surgery.

The five medical schools, selected to name seniors eligible for the awards for residency work starting in 1953, are the University of Kansas, Lawrence, Kansas; the University of Wisconsin, Madison, Wisconsin; Medical College of Virginia, Richmond, Virginia; the University of Rochester, Rochester, New York, and the University of Washington, Seattle, Washington.

### POSTGRADUATE COURSES

The Michael Reese Hospital Postgraduate School is offering the following courses:

1. April 14-18, 1952. Surgery, Indications, Pre- and Postoperative Care.
2. April 21-25, 1952. Clinical Dermatology—Refresher Course in Diseases of the Skin for General Practitioners.
3. April 28 to May 9, 1952. Diseases of the Endocrines—Physiology and Diagnostic Methods.
4. May 12-24, 1952. Recent Advances in Internal Medicine.
5. May 26-31, 1952. Recent Advances in Pediatrics.

For further information address Dr. Samuel Soskin, 29th St. and Ellis Ave., Chicago, 16.

### VANDERBURGH COUNTY MEDICAL-CIVIC DINNER

Vanderburgh County Medical Society's most recent public relations project, a Medical-Civic dinner the evening of March 4, gave doctors an opportunity to have their fellow citizens in Evansville know them better as an organization. More than 100 industrial, business, civic, religious and labor leaders were guests of the medical society in the McCurdy Hotel. Frank Sparks, president of Wabash College, made the address of the evening. Certificates of appreciation and recognition were awarded to the twenty-five living past presidents of the society. Dr. J. William Wright, president of the Indiana State Medical Association, spoke briefly and presented the certificates. Dr. R. L. Kleindorfer, society president, in a brief address of welcome pointed out that medicine has started to put its own house in order and is now doing something about the things for which it has been criticized. The Vanderburgh County Medical Society hopes to make this dinner an annual traditional event. In addition to the invited guests, more than 100 physicians were on hand. Dr. E. L. Fitzsimmons, president-elect of the society, was chairman of the committee in charge of arrangements.

### 1951 SUPPLEMENT TO REVIEWS OF MEDICAL MOTION PICTURES NOW AVAILABLE

The Committee on Medical Motion Pictures of the A.M.A. has completed the 1951 supplement to the second revised edition of the booklet entitled "Reviews of Medical Motion Pictures." This supplement contains 90 reviews of medical and health films reviewed in *The Journal of the A.M.A.* from January 1, 1951, through December 31, 1951. Each film has been indexed according to subject matter. The purpose of these reviews is to provide a brief description and an evaluation of motion pictures which are available to the medical profession.

Copies have been sent to the secretary of each of the State Medical Societies. Complimentary copies will be sent to county medical societies and other medical organizations upon request.

**The Indiana Public Health Association** will meet at the State Board of Health in Indianapolis, April 29 and 30. Registration begins at 9:30 a.m.; the meeting at 1:30 p.m. The Annual Banquet will be held the night of April 29 in the Travertine Room at the Lincoln Hotel. J. B. Carr, D.D.S., of Indianapolis, is president, and F. R. N. Carter, M.D., of South Bend, is vice-president. A cordial invitation is extended to all physicians to attend this meeting.

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**Dr. Harry S. Feinn** has opened an office for the practice of ophthalmology and otolaryngology in LaPorte. He is a 1937 graduate of Loyola University, and took postgraduate work in his specialty at the University of Illinois and Northwestern University. He is a veteran of World War II, with five and one half years' duty in China and India.

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**Dr. C. C. Van Tassel**, of Indianapolis, is stationed at the U.S. Army Hospital in Camp Cooke, California.

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**Dr. Robert E. Jewett**, who has served as director of the Division of Maternal and Child Health of the Indiana State Board of Health, became a member of the Council on Medical Education and Hospitals of the A.M.A. on March 1.

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**Dr. Joseph L. Sheridan**, a 1943 graduate of Indiana University School of Medicine, is now in neuropsychiatric practice in Washington, D. C.

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A 1950 graduate of Indiana University School of Medicine, **Dr. Jack L. Harvan** is now in practice in Carlsbad, New Mexico.

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**Dr. Robert L. Mather**, a 1947 graduate of Indiana University School of Medicine, is now in service with the Air Force at Lackland Air Force Base in San Antonio, Texas.

#### MANUSCRIPT EDITING

The American Medical Writers' Association has made arrangements with a well known school of journalism associated with a university having a medical school, where manuscripts will be reviewed by an instructor in the school. It is designed to help authors who wish to submit articles to medical journals or kindred publications. The service is available both to members and non-members of the Association, for which there is a nominal charge. Further information may be obtained by writing to American Medical Writers' Association, 209 W.C.U. Building, Quincy, Illinois.

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**Housing the Aging** is the topic for the University of Michigan Fifth Annual Conference on Aging to be held in Ann Arbor, Michigan, July 24-26, 1952. The Michigan State Medical Society is one of the cosponsors, and physicians are invited to attend. Conference registration materials may be obtained by writing to Dr. Wilma Donahue, Institute for Human Adjustment, Room 1510, Rackham Bldg., Ann Arbor, Michigan.

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**Dr. Walter L. Bruetsch**, of Indianapolis, has been appointed to serve as a member of the editorial board of the journal *Neuropsychiatry*, published in Buenos Aires by the Argentine Ministry of Public Health.

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**Dr. Thurman B. Rice**, of Indianapolis, has been named State Campaign Chairman of the Indiana Cancer Society.

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**Dr. Alton H. Ridgway**, a 1942 graduate of Indiana University School of Medicine, has returned to this country, to take a residency in surgery at the Indiana University Medical Center, after four years abroad as a medical missionary. He spent one year in Belgium and three years in the Belgian Congo in Africa.



**A.M.A. WASHINGTON OFFICE NEWS****C.D.A. ADVISES SELECTIVE BLOOD GROUPING  
RATHER THAN MASS GROUPING PROGRAM**

Civil Defense Administration, in response to queries, recommends that communities work out a selective blood grouping program rather than mass blood grouping, in order to build up reservoir of *volunteer group "O" donors for emergency use*. C.D.A. said selective blood grouping of reasonable number of volunteers should be done in advance in locations where they will be available for emergency service at hospitals or standby donor centers. Also proposed were (a) issuance of identification tags or cards to blood volunteers and (b) establishment of roster of "O" donors at places outside target areas.

"In this way, communities close to target area cities can be prepared to provide at once a supply of group 'O' blood sufficient to meet initial blood transfusion needs in the first hours following enemy attack," C.D.A. states.

C.D.A. says that any attempt to give specific blood group transfusions during the first 24 to 72 hours following attack would complicate greatly the supply problem for large numbers of first aid stations and emergency hospitals. In addition, C.D.A. says, a careful and accurate mass grouping program, because it is expensive, must have lower priority in community disaster preparation than providing adequate supplies of whole blood transfusion units, plasma and plasma extenders, burn dressings and other first aid station supplies.

**AMA URGES SENATE COMMITTEE CONSIDER  
DEFERMENT OF MEDICAL STUDENTS**

American Medical Association has requested the Senate Armed Services Committee to consider amending universal military training legislation so that pre-medical and medical students would be deferred from serving 7½ years in the reserve, once their basic 6-month training was over, until they have completed their professional training. The proposal was made by Dr. F. J. L. Blasingame, AMA trustee who earlier appeared before the House Armed Services Committee on the same subject.

**NATIONAL ADVISORY COMMITTEE CAUTIONS  
HOSPITALS ON SELECTING RESIDENTS**

National Advisory Committee to Selective Service advises hospitals to attempt to select their residents for 1952-53 *in the reverse order of their priority under the Doctor-Draft law*, with none chosen from Priority I "except under very exceptional circumstances, and probably in no instance except where there is a question of servicing an isolated community hospital." The Committee also reiterates that information on registrants, submitted for the purpose of re-opening their cases, must come from the *chairman in the state* in which the individual is engaged in his professional activities and must be addressed to the man's local Selective Service Board. The National Committee explained that information on the registrant should come from the *state chairman* rather than the *local committee* where he is located to avoid "putting one hospital out of line" with the other hospitals in the affected city.

**DEFENSE DEPARTMENT CONSIDERS  
INVOKING DOCTOR DRAFT LAW**

Because the pool of Priority I reserves is about exhausted, Defense Department is preparing to call on Selective Service to start inducting *physicians* under the doctor-dentist draft law (P.L. 779, Eighty First Congress), possibly as early as April.

Explaining the situation, one Defense Department official said that only a large influx of Priority I men into the reserves in the next few weeks would postpone use of the draft.

To date less than half a dozen physicians actually have been drafted. If the draft is resorted to now, it will be aimed at a group of about 1,000 Priority I physicians *who are physically fit, are not in essential civilian service but who have neither joined the reserves nor indicated they intend to*. Of the others in Priority I, about 1,500 have been deferred because of the essential nature of their civilian practice or status, and 2,000 have been found physically unfit for military service. The remainder are in the reserves, and either on active duty or awaiting orders.

#### ONLY FOUR 'CRITICAL TARGET' STATES NOT ACTIVE IN CD MEDICAL STOCKPILING

Federal Civil Defense Administration's medical supply stockpiling program now is moving ahead after a year of delays, mostly due to reluctance of some states to appropriate matching money. As late as December 1, CDA reported that 15 states containing critical target areas had not yet entered the program. Within the last two months, however, *all but four of these either submitted acceptable plans to Washington or are busy working out plans.* The funds, matched by states, will be spent for emergency medical supplies, to be stockpiled locally for use immediately after an attack.

CDA disclosed that the situation was changing for the good in announcing allocation of more than \$8 million to 14 states for local medical stockpiles, including such items as burn dressings, litters, blood plasma, antibiotics and surgical instruments.

States already participating in the program, with total budgets for each, are:

California .....	\$3,984,638
Colorado .....	39,632
Connecticut .....	303,903
Delaware .....	50,275
Kansas .....	97,549
Maryland .....	398,231
Massachusetts .....	298,674
Michigan .....	793,707
New Jersey .....	552,360
New York .....	9,486,896
Oregon .....	15,504
Rhode Island .....	3,766
Tennessee .....	197,430
Washington .....	498,666

Although states are paying half the costs, most of the funds will be expended through CDA, to take advantage of bulk purchasing while at the same time not exceeding the capacity of manufacturers. Federal Civil Defense Administration also has about \$33 million available for setting up and maintaining regional warehouses for medical supplies. These stocks, *paid for entirely by U. S.*, will be held in reserve, to be rushed in to an attacked area to supplement local supplies after the first few hours.

#### MRS. ROSENBERG SAYS DEPENDENTS OF SERVICEMEN ARE GETTING LESS MEDICAL CARE

Testifying in favor of the military pay raise bill, Assistant Defense Secretary Anna Rosenberg said the military services currently are able to give medical care to *fewer dependents* than in

past years. She gave this as one reason why a pay increase is justified.

Technically, medical care is authorized for dependents *only when professional personnel and facilities are "available."* Mrs. Rosenberg explained that the present situation had developed because of (a) increasing numbers of military personnel who have first claim to medical care, (b) shortages of professional personnel and facilities, particularly hospital beds, and (c) the necessity for keeping large numbers of beds ready for Korean casualties.

Also, Mrs. Rosenberg said the military departments' medical budgets were so low as to leave little money to provide care for wives, children and other dependents. For fiscal 1953, she declared, military departments were budgeted at an average of \$120 or less for each uniformed member for a year's medical care (Army \$107, Navy \$120 and Air Force \$117). Construction and maintenance costs of hospitals are not included in the totals.

#### ADMIRAL BOONE FORESEES "DIFFERENT KIND OF ORGANIZATION" IN VA SOON

Vice Admiral Joel T. Boone, chief medical director of Veterans Administration, states that *"we can assume a different kind of organization"* will be created within VA following completion of the management survey by Booz, Allen and Hamilton. He said the *Department of Medicine and Surgery*, like other VA operations, would be affected. The private consultants have been studying all phases of VA operations since January, 1951. Their report, according to VA Administrator Carl R. Gray, Jr., will be made public in about 60 days.

Admiral Boone's comments came during an American Legion Rehabilitation conference at which he was asked what had been done to carry out recommendations of the Humphrey subcommittee for changes in the VA medical setup.

The VA medical chief explained that the Humphrey recommendations dealing with administrative action "are being complied with or will be" by the time the management survey is completed. He then said that it was natural to assume there would be changes "when \$600,000 of the taxpayers' money" was being spent on the Booz, Allen and Hamilton study. Admiral Boone reiterated that Gen. Gray had given him the authority he needs to do his job as medical chief.



## *Indiana University News Notes*

The Indiana University Medical Center was host to executives of University Hospitals throughout the Midwest on Thursday and Friday, January 24 and 25. This was the first visit of the group to the campus since 1941.

Representatives were in attendance from the hospitals of the University of Chicago, University of Michigan, University of Minnesota, Western Reserve University at Cleveland, University of Rochester at Rochester, N. Y., the University of Wisconsin, and University of Iowa. The Indiana University delegation was headed by Dr. John D. VanNuys, dean of the School of Medicine, and Mr. J. B. H. Martin, administrator.

Sessions were presided over by Dr. Gerhard Hartman, superintendent of the University of Iowa Hospitals, secretary, in the absence of Dr. Basil McClean, director of the University of Rochester Hospital.

The campus was host to a group of noted orthopedic surgeons the week end of February 1. Coming from all parts of the United States for an annual meeting here the group were guests of Dr. George J. Garceau. Known as the Orthopedic Travel Club, the surgeons observed several cases and participated in informal discussions.

Dr. Gerald W. Gustafson, Professor of Obstetrics and Gynecology, conducted a written examination for the American Board of Obstetrics and Gynecology at the Medical School on Friday, February 1.

Allen Beck, head of the Medical Center's pharmacy, has been named chairman of the Public Relations Committee of the American Society of Hospital Pharmacists and is arranging a program for the society's annual meeting to be held in Philadelphia in August, in connection with the centennial meeting of the American Pharmaceutical Association.

A year's leave of absence was granted Dr. Donald J. Caseley, medical director of the Indiana University hospitals, by the University trustees at a meeting on January 18. Dr. Caseley has been named as associate director of the Commission on Financing of Hospital Care. It will be in charge of medical phases of the Commission's study of costs of hospitalization.

Dr. A. David McKinley, assistant medical director, and other members of the staff are carrying on duties of the medical director's office during his absence.

Physicians from all parts of the state attended the annual postgraduate symposium on the Heart Tuesday, February 5, at which five distinguished authorities in the field were speakers. Speakers for the program, which was presented by the School of Medicine and the Indiana Heart Foundation, were Dr. Roy W. Scott, Cleveland; Dr. Thomas J. Dry and Dr. Edgar A. Hines, Jr., Rochester, Minn.; Dr. Robert W. Wilkins, Boston, Mass.; and Dr. Charles Friedberg, New York.

The speakers, with Dr. Kenneth Kohlstaedt as moderator, were heard in a roundtable discussion of heart problems that evening. The discussion was not only heard by a large group of physicians assembled in the auditorium of the School of Medicine, but also by a number of county medical societies over the long-distance telephone connections.

Twenty-five physicians, enrolled several weeks in advance, arrived on Wednesday, February 6, for the annual two-day postgraduate course in electrocardiography.

Dr. Harris B. Shumacker, Jr., Dr. Edwin A. Lawrence, Dr. Thomas Moore and Dr. Arnold Kunkler attended meetings of the Society of University Surgeons and the Society of Clinical Surgery held in Baltimore, Md., the week of February 3. Dr. Moore presented a paper before the University Surgeons group.

A three-day clinic, opening on February 12, was conducted by Dr. M. H. Cottle of Chicago, on the Restoration of Nasal Function by the Surgical Reconstruction of the Nose. The clinic was under the auspices of the Department of Otorhinolaryngology. Thirty-seven ear, nose and throat specialists from 13 states and members of the staff were enrolled for the course.

Dean John D. VanNuys and Dr. John J. Mahoney were in Chicago for the mid-winter meeting of the Association of American Medical Colleges and the meeting of the Council on Medical Education and Hospitals.

Arrangements are being completed for a dinner meeting of the Hoosier State Press Association on the Medical Center campus Friday evening, April 25. The meeting will bring newspaper editors and publishers from all parts of the state to the campus as a part of their annual convention.

Dr. Joseph L. Morton, widely known for his work with radioactive cobalt as a substitute for radium in the treatment of cancer, was a guest on the Medical Center campus, February 21-22, and discussed his studies and procedures before a meeting of Indiana radiologists. Doctor Morton, radiologist for the Ohio State University hospitals, was the guest here for a series of conferences and discussions arranged by the Department of Radiology of the Indiana University School of Medicine with the support of the Indiana Cancer Society.

Announcement has been made that the Indiana Hospital Association will hold its annual meeting in Indianapolis on June 13. Several members of the Medical Center staff will participate in the program.

Construction projects on the campus are making constant progress. The new book stacks have been installed in the Medical School library; new water softening equipment is being installed at the power plant, forms are being set for completion of the second floor of the new Union Building, and it is anticipated that work will be completed for the rooming-in quarters at Coleman Hospital within the next few days. Ward 'A' at Coleman was opened the first week in January after complete remodeling and redecoration.

County medical groups over the state heard the Telephone Seminar program presented from the Medical School Auditorium Tuesday, January 8.

Those who participated in the program on 'Medical Emergencies' were Dr. J. O. Ritchey, chairman and professor of the Department of Medicine; Dr. Alexander T. Ross, chairman of Department of Neurology and Psychiatry and professor of Neurology; Dr. Reuben A. Solomon, clinical professor in Department of Medicine; Dr. Charles E. Test, instructor in Department of Medicine; Dr. Donald E. Wood, assistant professor of Department of Medicine and Dr. William D. Province of Franklin, Ind., internist.

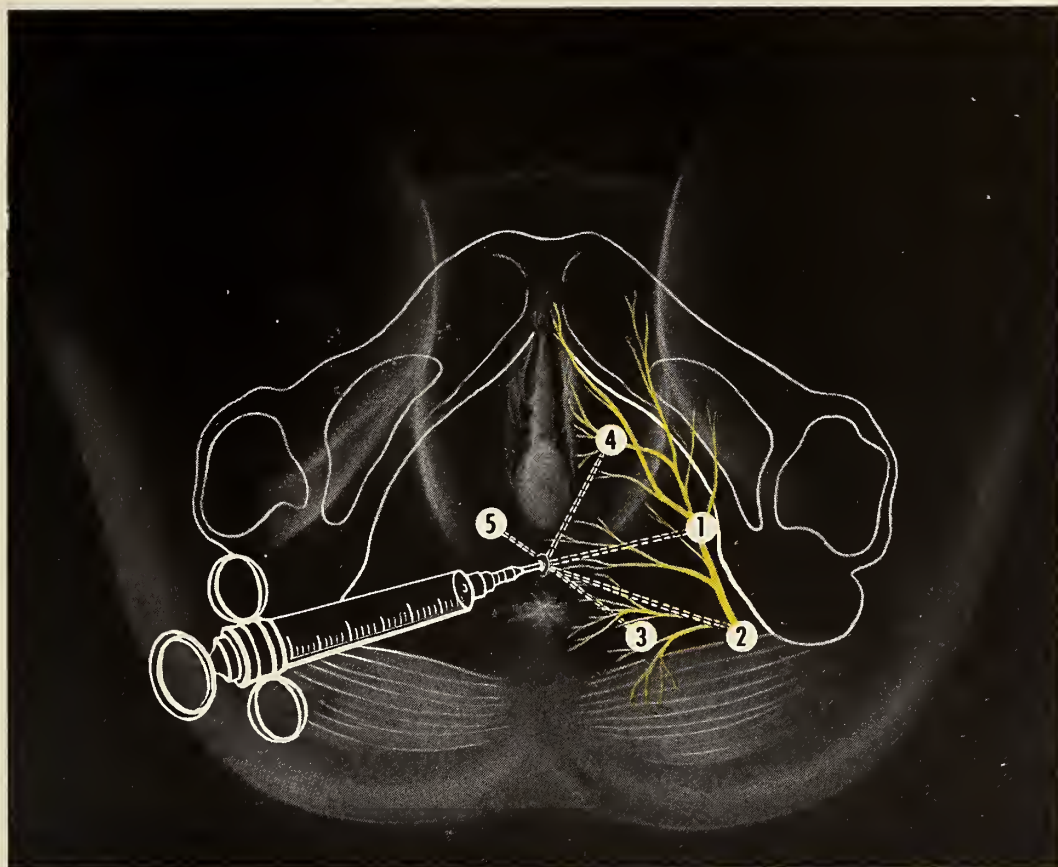
Healing the human body requires your skill  
Healing the body politic requires your will

**YOUR VOTE IS VITAL!**

So Be Sure You and Your  
Family Are Registered—

**BE SURE YOU  
VOTE!**





Sites for injection of local anesthesia in obstetrics. Sites 1 to 4 should be similarly injected on the contralateral side. Site 5 is for episiotomy. Adapted from Johnson, O. J.: Nerve Block in Painless Childbirth, J.A.M.A. 145:401 (Feb. 10) 1951.

## Pudendal Block in Obstetrics Simplified with **ALIDASE**

Using a local anesthetic with hyaluronidase, Heins<sup>1</sup> reports: "Complete perineal anesthesia is practically instantaneous. . . . The technique of pudendal block is greatly simplified. The operator does not have to inject the nerve per se, but infiltration in the vicinity of the nerve will accomplish an effective block."

Baum<sup>2</sup> states: "The use of hyaluronidase is found to be a safe and simple method for increasing the efficiency of pudendal block in obstetrics and for overcoming many of the objections to this type of obstetrical anesthetic."

**ALIDASE**<sup>®</sup>—highly purified, well tolerated brand of hyaluronidase—definitely shortens the period between completion of the block and establishment of operating analgesia. Swelling, induration and discomfort are almost negligible with Alidase.

<sup>1</sup>Heins, H. C.: Pudendal Block with Hyaluronidase, J. South Carolina M. A. 46:309 (Oct.) 1950.

<sup>2</sup>Baum, F. E.: The Use of Hyaluronidase in Pudendal Block, Am. J. Obst. & Gynec. 60:1356 (Dec.) 1950.



RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

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## Deaths

Lawrence W. Nehil, M.D., of Indianapolis, died on March 2, at the age of forty-six. A 1929 graduate of the University of Michigan Medical School, in Ann Arbor, he served as instructor in surgery at the University of Michigan until 1936, when he entered private practice in Louisville. He remained there until 1942, when he came to Indianapolis, where he had practiced ever since. Doctor Nehil was a member of the Indianapolis Medical Society, the Indiana State Medical Association, and the American Medical Association.

Fred W. Grayston, M.D., of Huntington, died on February 20, after a brief illness. He was eighty-one years of age. He was a graduate of the University of Illinois College of Medicine, Chicago, in 1895, and had practiced in Huntington since that time, until his retirement from active practice five years ago. Doctor Grayston was an Honorary member of the Huntington County Medical Society and the Indiana State Medical Association, and was a member of the American Medical Association.

William L. Grossman, M.D., of North Vernon, died on February 10 as a result of injuries sustained in an automobile accident on January 29. A 1907 graduate of the Illinois Medical College, in Chicago, he had practiced in North Vernon since that time. He was a member of the Jennings County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Oscar S. Heller, M.D., of Greenfield, died on February 14, following a long illness. He was seventy-nine years of age, and had practiced in the vicinity of Greenfield for fifty-four years. He was an 1897 graduate of the Medical College of Indiana, in Indianapolis, and was an Honorary member of the Hancock County Medical Society and the Indiana State Medical Association, and a member of the American Medical Association.

Herbert G. McMahan, M.D., superintendent of the Beatty Memorial State Hospital at Westville, died in Topeka, Kansas, as a result of burns. He was a 1936 graduate of Indiana University School of Medicine, and had served as superintendent of the State Hospital in Manteno, Illinois, before going to Westville. He was forty-one years of age. Doctor McMahan was a member of the LaPorte

County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Harry N. Swezey, M.D., of Lafayette, died on February 12, after a brief illness. He was seventy-three years of age. After graduating from Rush Medical College, in Chicago, in 1901, he practiced in Marion until 1905, when he returned to Rush Medical College for postgraduate work in ophthalmology and otolaryngology. He returned to Marion to practice until 1911, when he began the practice of his specialty in Lafayette, where he had practiced ever since. Doctor Swezey was a member of the Tippecanoe County Medical Society, the Indiana State Medical Association, and the American Medical Association.

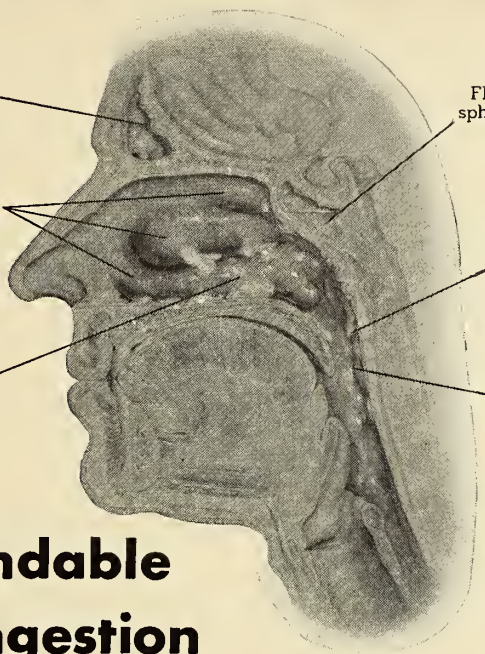
Ernest E. Parker, M.D., of Oxford, died on February 9, at the age of seventy-seven. He graduated from the Kansas Homeopathic Medical College, in Kansas City, in 1901, and practiced in Stone Bluff prior to moving to Oxford in 1903, where he practiced until his death. Doctor Parker was an Honorary member of the Benton County Medical Society and the Indiana State Medical Association, and a member of the American Medical Association.

Louis J. Downey, M.D., retired physician of Plainfield, died on January 3, at the age of seventy-six. He graduated from the Washington University School of Medicine, in St. Louis, in 1902, and practiced in Vincennes until 1943, when he accepted an appointment at the Boys School at Plainfield. He retired from that position in July 1951.

Milburn W. Kemp, M.D., of Madison, died suddenly on February 6. He was fifty-seven years of age. He was a 1920 graduate of the University of Toronto Faculty of Medicine, and had practiced in mental hospitals in Michigan, Minnesota and Illinois before coming to the Madison State Hospital in 1947. He was a member of the Jefferson County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Allen J. Shonkwiler, M.D., former Rockville physician, died in Evansville on January 10, at the age of seventy-two. He was a 1905 graduate of the Medical College of Indiana, in Indianapolis, and had practiced in New Castle until his retirement.





Exudate in frontal sinus

Fluid level in sphenoid sinus

Reddened and swollen turbinates

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Pharyngitis

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*in*

*colds,*

*sinusitis, allergic rhinitis*

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## Society Reports

### INDIANA STATE MEDICAL ASSOCIATION

#### EXECUTIVE COMMITTEE

February 17, 1952

Roll call showed the following present: J. William Wright, Sr., M.D.; Paul D. Crimm, M.D.; Wemple Dodds, M.D.; Roy V. Myers, M.D.

Frank B. Ramsey, M.D., editor of *THE JOURNAL*; Albert Stump, attorney; James A. Waggener, executive secretary.

Guests: Cleon A. Nafe, M.D., chairman, Indiana A.M.A. Campaign Coordinating Committee; Elmer C. Paul, Indiana State Police.

Doctor Nafe appeared before the committee to discuss the recent ruling of the Internal Revenue Department regarding division of fees between surgeons and assisting physicians, and requested the association attempt to procure a ruling from the Internal Revenue Department on this matter. The secretary stated that a letter had been sent to the collector at Indianapolis and a reply had been received indicating that when fees were paid assistants for services actually rendered it was the opinion of the collector that this could be allowed as a deductible item on income tax. The secretary was instructed to carry this matter further and attempt to procure a ruling from the Washington Bureau through the A.M.A. Doctor Crimm carried the matter to Chicago for a discussion there regarding this matter.

#### Membership Matters

##### Membership report:

Number of members, January 31, 1952	2,205
Number of members, January 31, 1951	2,123
Gain over last year	82
Number who have paid 1951 AMA dues	2,913
Number who have paid 1950 AMA dues	2,898

Upon motion of Drs. Myers and Crimm the secretary is to write the Porter County Medical Society regarding the request for honorary membership for Dr. Fred L. Adair.

The secretary reported on the latest ruling from the American Medical Association regarding delinquent members, in which it has been ruled that a member must pay for the year in which he becomes delinquent and the year in which he requests reinstatement before he is accepted as an active member in the A.M.A.

#### Treasurer's Office

The treasurer reported that \$10,000 from *THE JOURNAL* fund has been invested in U. S. Savings bonds, Series G, and placed in the General Fund securities at the Indiana National Bank.

Statements of receipts and expenditures for January for the association and *THE JOURNAL* were approved.

#### Headquarters Office

The secretary presented an idea to simplify the collection of state association and A.M.A. dues. The method was approved by consent, and the secretary is to report the cost and exact form to be used at the next meeting.

#### 1952 Annual Session, Indianapolis, October 28, 29 and 30, 1952:

*Program.* By consent, the following was agreed upon by the committee:

- a. The annual banquet will be held the last night of the annual session, on October 30.
- b. The first session of the House of Delegates will be held at 7:30 a.m. on Tuesday, October 28, and will be a breakfast meeting, with the final session of the House being held on Thursday morning, October 30.

*Exhibits.* The floor plan for the 1952 annual session, moving the registration facilities to the front of the exhibit hall, was approved by consent.

By consent, it was agreed that there should be a one-hour break in both morning and afternoon in the scientific program for viewing of exhibits.

Upon motion of Drs. Dodds and Crimm, it was agreed that the acceptance of exhibits will be on the basis of their being approved by the appropriate council of the A.M.A.

#### Future Meetings

The executive secretary was authorized to attend the meeting of the Board of Directors of the Indiana State Chamber of Commerce at French Lick on April 4, 5 and 6, 1952.

#### Legislative Matters

##### National

Resolution opposing UMT, as adopted by the AAPS, and a resolution from the Medical Society of the State of North Carolina disapproving insurance benefits under any policy being paid to Veterans Hospitals were called to the attention of the committee.

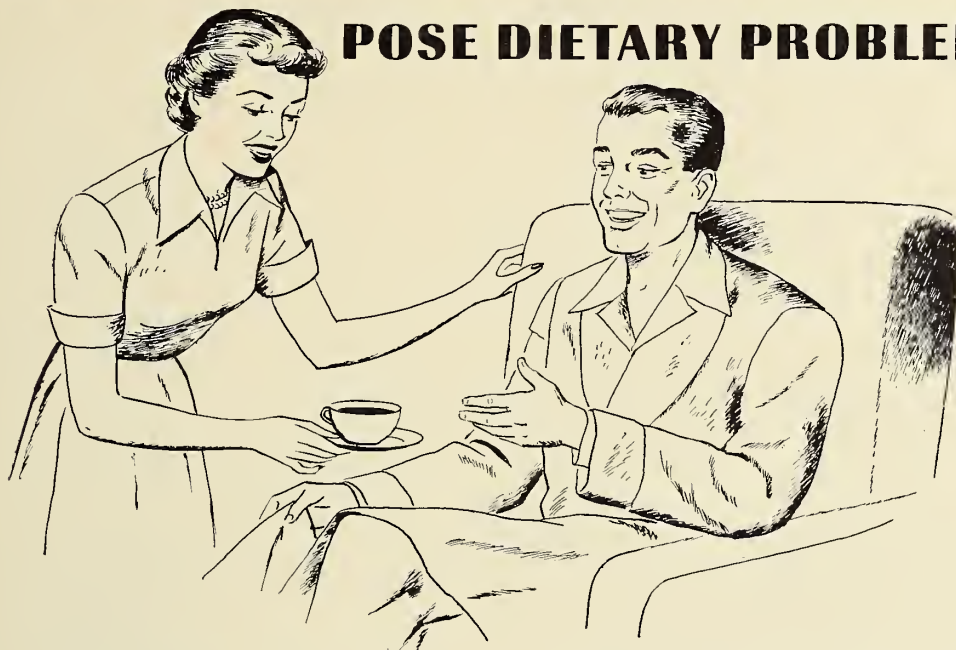
The request of the Indiana State Chamber of Commerce for the association to oppose the Moody-Dingell bill in Congress was approved by consent, and the headquarters office instructed to prepare a suitable letter to the Congressmen of Indiana, voicing opposition to this proposal.

##### Local

The secretary reported his discussion with Dr. E. S. Hamilton, a member of the Board of Trustees of the A.M.A., and also a member of the Board of Medical Registration of Illinois, regarding the Lake



# When Functional Derangements POSE DIETARY PROBLEMS



In the interest of maintaining good nutrition in the patient, many functional derangements of the gastrointestinal tract make the use of a well rounded dietary supplement, such as Ovaltine in milk, highly advantageous. Among such functional derangements more commonly encountered are nausea, anorexia, gastritis, diarrhea, dysentery, enteritis, and colitis.

In these conditions, Ovaltine in milk is particularly useful, not only because of its

easy digestibility but also because of its blandness and its high nutrient content. It offers the opportunity of providing a balanced fare of essential nutrients without mechanical irritation or excessive digestive demands. Hence it qualifies especially when customarily eaten foods are contraindicated and a nutritious bland diet is required.

The wealth of nutrients supplied by three glassfuls of Ovaltine in milk is outlined in the table below.

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CARBOHYDRATE . . . . .	65 Gm.	VITAMIN D . . . . .	420 I.U.
FAT . . . . .	30 Gm.	ASCORBIC ACID . . . . .	30 mg.
CALCIUM . . . . .	1.12 Gm.	NIACIN . . . . .	6.7 mg.
COPPER . . . . .	0.7 mg.	PANTOTHENIC ACID . . . . .	3.1 mg.
IODINE . . . . .	0.7 mg.	PYRIDOXINE . . . . .	0.6 mg.
IRON . . . . .	12 mg.	RIBOFLAVIN . . . . .	2.0 mg.
PHOSPHORUS . . . . .	940 mg.	THIAMINE . . . . .	1.2 mg.
CALORIES . . . . .	658		

Two kinds, Plain and Chocolate Flavored. Serving for serving, they are virtually identical in nutritional content.



County resolution requesting reciprocity between states for physicians attending patients living across state lines.

#### Organization Matters

Upon motion of Drs. Crimm and Dodds the committee disapproved the request of the Board of Appeals for special stationery.

On motion of Drs. Myers and Crimm, six subscriptions to the Shearon legislative letter were approved.

Upon motion of Drs. Dodds and Crimm, the purchase of a page advertisement in the Hoosier State Press Association publication for their annual convention was approved.

The committee approved the location of Brown County for an association scholarship recipient.

Letter of appreciation from Dr. A. C. Yoder was read to the committee.

By consent, it was agreed to ask Dr. William H. Lane to participate in a panel discussion at the annual session of the Indiana Hospital Association.

Sergeant Paul of the Indiana State Police explained a traffic study being made by his department, similar to that being conducted in the aircraft industry by Cornell University. He requested special cooperation on the part of Indiana physicians in filling out a special form on all fatalities from automobile accidents. The committee approved the form and the cooperation by physicians, and information on this is to be carried in *THE JOURNAL*.

#### The Journal

##### *Report on advertising:*

Total, January and February, 1952—\$4,134.03

Total, January and February, 1951—4,293.81

Loss over last year, first two months—161.78

The request of Doctor Ramsey, editor of *THE JOURNAL*, for permission to carry four illustrations instead of two on scientific subjects was authorized by consent.

The request of a physician for publication of an insurance assignment form in *THE JOURNAL* was not granted.

There being no further business, the committee adjourned to meet again on March 16, 1952, at the Columbia Club, Indianapolis.

#### COMMITTEE ON PUBLICITY

January 25, 1952

Present: D. S. Megenhardt, M.D., chairman; James O. Ritchey, M.D.; Homer G. Hamer, M.D., and Jas. A. Waggener, executive secretary.

The following "Hints on Health" columns were approved:

Week of March 2, 1952—"Measles"

Week of March 9, 1952—"Start Baby Right"

Week of March 16, 1952—"Cat-scratch Fever"

Week of March 23, 1952—"Hypoproteinosis"

The secretary reported that Miss Sally Butler had accepted the invitation of the committee to address a group at Marion, the evening of January 24, 1952.

#### COMMITTEE ON PUBLICITY

February 15, 1952

Present: D. S. Megenhardt, M.D., chairman; J. O. Ritchey, M.D.; and Jas. A. Waggener, executive secretary.

The following "Hints on Health" Columns were approved:

Week of March 31, 1952—"Infant Mortality"

Week of April 7, 1952—"Lead Poisoning"

Week of April 14, 1952—"Accident Prone"

Week of April 21, 1952—"Your Sight"

#### COUNTY MEDICAL SOCIETY OFFICERS

##### DECATUR COUNTY MEDICAL SOCIETY

President, Charles F. Overpeck, Greensburg

Vice-President, W. C. Callaghan, Greensburg

Secretary-Treasurer, William T. Sallee, Greensburg

##### DEKALB COUNTY MEDICAL SOCIETY

President, F. B. Kantzer, Garrett

Vice-President, E. E. Rogers, Auburn

Secretary-Treasurer, Max Wills, Auburn

##### DUBOIS COUNTY MEDICAL SOCIETY

President, Harvey K. Stork, Huntingburg

Vice-President, Fielding P. Williams, Huntingburg

Secretary-Treasurer, Henry G. Backer, Ferdinand

##### HAMILTON COUNTY MEDICAL SOCIETY

President, F. P. McDaniel, Atlanta

Vice-President, Harold Shonk, Noblesville

Secretary-Treasurer, Eugene Newby, Sheridan

##### JAY COUNTY MEDICAL SOCIETY

President, John Engle, Portland

Vice-President, Ralph Steffy, Portland

Secretary-Treasurer, S. M. Hammond, Portland

##### JOHNSON COUNTY MEDICAL SOCIETY

President, Kenneth Sheek, Greenwood

Vice-President, John Machledt, Whiteland

Secretary-Treasurer, Arthur W. Records, Franklin

##### MARSHALL COUNTY MEDICAL SOCIETY

President, L. W. Vore, Plymouth

Vice-President, R. L. Witham, Culver

Secretary-Treasurer, James Kubley, Plymouth

##### OWEN-MONROE COUNTY MEDICAL SOCIETY

President, Ray Borland, Bloomington

Vice-President, W. J. Stangle, Bloomington

Secretary, E. B. Quarles, Bloomington

Treasurer, Naomi Dalton, Bloomington

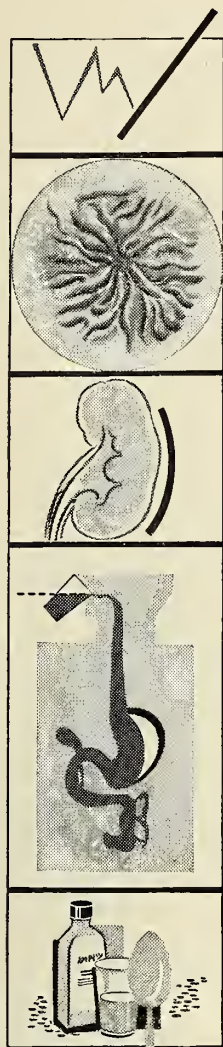
#### LOCAL SOCIETY REPORTS

Camp Atterbury Medical Society members held their regular meeting on February 20 at the U. S. Army Hospital. Major F. E. Schwartz, who recently returned from Korea, gave an illustrated talk on Korea. New officers for the year were elected.



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relieves pain promptly

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promotes rapid healing

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no kidney damage

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buffers gastric contents moderately; permits normal neutralization of alkaline secretions of upper intestine

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even in excessive doses. Does not cause unphysiologic alkalinity and consequent acid secretory response

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smooth, creamy, pleasing taste and texture



SUPPLIED: Liquid, bottles of 12 fl. oz. Also available: Tablets of 5 grains and 10 grains

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Allen County Medical Society members met at the Chamber of Commerce in Fort Wayne on February 5. Fifty members were present. Dr. Frederick Steigmann, of Chicago, gave an illustrated talk on "Jaundice."

---

Boone County Medical Society members met at the Witham Memorial Hospital in Lebanon on March 4, to participate in the telephone seminar.

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Cass County Medical Society members held a meeting at Memorial Hospital in Logansport on March 4. Nineteen members were present to participate in the telephone seminar and attend the business session.

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Clinton County Medical Society members met at the home of Dr. W. W. Jones in Frankfort on February 5.

---

Dubois County Medical Society members met at the Ideal Hotel in Huntingburg on February 14, when ten members were present. This was a joint dinner meeting with the Woman's Auxiliary, following which separate business meetings were held.

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Fountain-Warren County Medical Society held a meeting on February 7 at Veedersburg. Dr. L. P. Harshman, of Fort Wayne, spoke on "Headache." Twelve members were present.

---

Jay County Medical Society members met at the Country Club in Portland on March 5. This was a dinner meeting, and eleven members were present. The speaker was Dr. William E. Sutton, of Indianapolis, whose subject was "Office Urology."

---

Johnson County Medical Society members met at the Johnson County Memorial Hospital on February 13. Twelve members were present, to hear a discussion on laboratory studies.

---

LaPorte County Medical Society met at the Rumley Hotel in LaPorte on February 22. Thirty-six members were present to hear Dr. Fred Shapiro, of Chicago, speak on "Back Pain From the General Practitioner's Viewpoint."

---

Lawrence County Medical Society members met at the Dunn Memorial Hospital in Bedford on February 13. Fifteen members were present to hear a recording on "Heart Round Table."

---

Marshall County Medical Society members met at the Coral Gables Restaurant in Plymouth on March 5. Eight members were present to hear a wire recording of a heart symposium.

Montgomery County Medical Society members met at the Culver Hospital in Crawfordsville on February 21. Twenty-one members were present to hear the wire recording of the "Heart Round Table."

---

Morgan County Medical Society members met at the Off Hand Manor in Martinsville. This was a dinner meeting with members of the Woman's Auxiliary, followed by a business meeting. Eleven members were present.

---

Owen-Monroe County Medical Society members met at the Bloomington Country Club on January 31. Dr. Robert Jenkins, of Indianapolis, spoke on "Common Dermatoses Seen In General Practice." Thirty-one members were present.

---

Parke-Vermillion County Medical Society members met at the Vermillion County Hospital in Clinton on February 20. Dr. John M. Kercheval, of Clinton spoke to the fourteen members present on "Carcinoma of the Breast."

---

Putnam County Medical Society members met at the DePauw Union Building on February 8. Nineteen members were present to discuss public welfare problems.

---

Vanderburgh County Medical Society members met at the Hotel McCurdy in Evansville on February 12. Dr. Henry A. Szujewski, of Chicago, discussed the chemosurgical treatment of cancer.

---

Wabash County Medical Society members met at the Wabash Country Club on February 13. Dr. John F. Phillips of Fort Wayne spoke on "Pitfalls In the Management of Heart Diseases." Sixteen members were present.

---

Washington County Medical Society met at the Washington County Memorial Hospital on February 11. Five members were present for the business meeting.

---

Wells County Medical Society members met at the Caylor-Nickel Clinic in Bluffton on February 18. Fifteen members were present.

---

Whitley County Medical Society members met at the Whitley County Memorial Hospital on February 12. Dr. John Weber, of Fort Wayne, spoke on "Frequent Problems in Pediatrics." Ten members were present.



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SODIUM ASCORBATE

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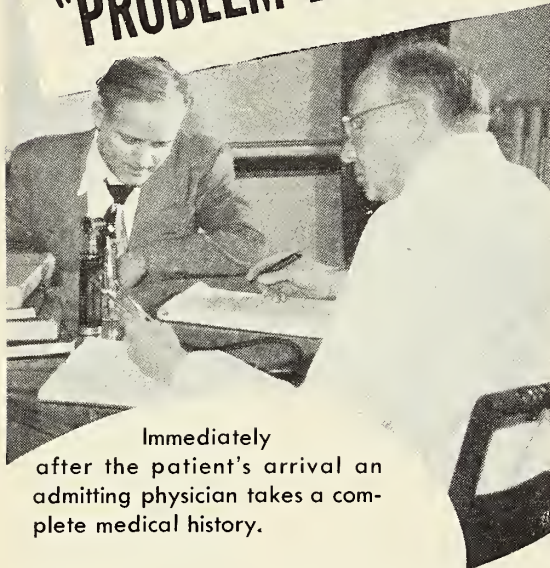
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# Individualized Care for the "PROBLEM DRINKER"



Immediately  
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admitting physician takes a complete  
medical history.

Treatment of the alcoholic is more than a sobering-up process; it is a rehabilitative procedure tailored to the needs of the individual.

The physicians at The Keeley Institute have had many years' experience in treating this class of patient and are specialists in their chosen field.

On arrival the patient is taken in hand by an admitting physician who obtains a complete medical history. This constitutes the first step toward instituting individualized care and treatment.

Subsequently, following a thorough physical examination and indicated laboratory studies, a detailed course of management can be outlined. It should be emphasized that no patient is continued under treatment unless he recognizes his problem and cooperates with the staff physicians.

*[ This is the first of a series outlining the successive steps in the treatment of the "Problem Drinker" under Keeley management. ]*

Complete information, including rates, will be furnished to physicians on request.

**THE KEELEY INSTITUTE**  
**DWIGHT, ILLINOIS**

## WOMAN'S AUXILIARY to the Indiana State Medical Association

**President**—Mrs. F. M. Fargher, Michigan City.

**President-Elect**—Mrs. Hubert T. Goodman, Terre Haute.

**Corresponding Secretary**—Mrs. Victor F. Kling, Michigan City.

**Recording Secretary**—Mrs. Elmer Singer, Fort Wayne.

**Treasurer**—Mrs. Robert Bolin, Elkhart.

**Publicity**—Mrs. F. M. Gastineau, Indianapolis.

The Woman's Auxiliary to the Indiana State Medical Association has planned two Health Workshops for women in rural communities. The first one was held at the Lancaster Township School, north of Bluffton, on March 27. There were panel discussions on heart, cancer, nutrition and mental hygiene. A similar program is planned for the workshop to be held at Bloomington on May 21. Mrs. J. L. Eisaman, of Bluffton, is rural health chairman.

## INDIANA STATE BOARD OF HEALTH

### Division of Communicable Disease Control

#### MONTHLY REPORT—JANUARY 1952

Disease	Jan. 1952	Dec. 1951	Nov. 1951	Jan. 1951	Jan. 1950
Chickenpox	489	389	146	367	341
Diarrhea,					
infectious	12	0	0	0	9
Diphtheria	3	5	17	5	26
Dysentery,					
Bacillary	1	0	0	0	0
Virus	16	1	18	0	0
Encephalitis	3	1	1	0	2
Erysipelas	3	2	0	0	0
Food infection	1	0	0	0	1
Impetigo	7	2	1	1	5
Influenza	67	46	74	51	53
Infectious hepatitis	24	22	16	4	0
Measles	849	440	95	211	211
Meningitis,					
Unclassified	3	7	7	7	5
Influenzal	1	0	0	1	2
Meningococcal	2	1	1	5	6
Mumps	537	288	132	167	183
Pneumonia	96	44	29	54	51
Poliomyelitis	3	11	32	5	11
Rabies in animals	12	27	20	19	29
Rheumatic fever	1	3	2	1	2
Rubella	31	20	13	8	23
Scarlet fever	190	182	104	178	192
Septic sore throat	3	4	8	8	2
Tinea capitis	1	0	0	5	1
Typhoid fever	2	1	2	2	6
Vincent's angina	4	0	0	0	1
Whooping cough	86	108	99	89	100
Trichinosis	2	2	0	0	0
Hookworm disease	5	0	0	0	0



# THE JOURNAL

OF THE

## INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

ISSUED MONTHLY *under Direction of the Council*

OFFICE OF PUBLICATION: 1017 Hume Mansur Bldg., INDIANAPOLIS 4, INDIANA

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VOLUME 45

MAY, 1952

NUMBER 5

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### SYMPOSIUM ON FLUID AND ELECTROLYTE BALANCE\*

#### FOREWORD

W. D. GATCH, M.D.

*Indianapolis*

Moderator

*The four papers which follow were presented at this symposium. Their authors have worked hard to prepare them. They merit careful study. They deal with the factors which regulate the quantity, composition, osmotic pressure, and reaction of the body fluids; with clinical and laboratory methods of determining the state of these fluids; with proper means of correcting derangements of this state. They therefore cover a wide territory. You will be impressed when you read them, as I was, with what the late Doctor Cannon called the wisdom of the body, here manifested by the miraculous way in which it, in health, keeps the quantity and composition of its fluid in a normal state. Our most refined methods for doing this are crude in comparison. The physician concerned with body water and electrolytes should let the body itself regulate these whenever possible. We give too many intravenous injections. After operation, early alimentation is more important than early ambulation.*

---

\* Presented at the annual session of the Indiana State Medical Association, at Indianapolis, October 30, 1951.

## THE PHYSIOLOGIC BACKGROUND FOR THE CLINICAL DISTURBANCES IN ELECTROLYTE AND FLUID BALANCE

KHALIL G. WAKIM, M.D.‡

*Rochester, Minnesota*

**I**N APPRAISING the significance of electrolyte and fluid balance in the management of surgical as well as medical patients with serious electrolyte and fluid disturbances, it is essential to keep in mind the fact that the circulating blood does not come into actual contact with the cells which depend on it for nourishment. Fluids are constantly escaping from blood capillaries and returning to the blood stream either directly or by way of the lymphatics. The total area of the capillary bed in the living organism is so vast that if every capillary in the body were filled to maximal capacity the volume of the blood in actual circulation would become dangerously insufficient. Krogh<sup>1</sup> estimated that if all the capillaries in the muscles of a man of average size were placed end to end they would stretch several times around the globe. The total area of the blood capillary endothelium is greater than that of a football field.

Such vastness may give the impression that nature is extravagant. This impression, however, can easily be avoided by the realization of the fact that the whole circulatory system is destined to reach every cell in the body to supply nutrients, oxygen, and repair materials to all the tissues and to free them of their wastes and other end-products or by-products of metabolism. The capillaries, insignificant as they may look, are the keystones of the circulation. The capillary bed is the only region in the vascular system where interchange of various substances between the blood and the tissues can occur. It is very important to remember that the whole cardiovascular system exists for the sole purpose of regulating blood flow through capillaries where the exchange of gases for tissue respira-

tion and the exchange of compounds and elements necessary for metabolism take place. Hence the zeal with which we interpret the importance of the heart, the aorta, and the rest of the large blood vessels should not shroud the paramount role played by the minute vessels in the body. If the capillaries of an area, for one reason or another, are put out of function, no matter how wonderful is the performance of the heart or how large a vessel carrying blood traverses that area, its tissues are bound to die (become infarcted and necrose) because of the failure of the medium (capillaries) for interchange of substances between the cells of that area and the blood.

### Fluid Compartments

The living body is made up of about 70 percent water,<sup>2</sup> which is anatomically distributed into three main compartments, namely: (1) the vascular tree, comprising the compartment which contains about 3 liters of fluid (about 5 percent of body weight) in the form of blood plasma; (2) the intracellular compartment, which contains about 29 liters of fluid (approximately 50 percent of body weight); and (3) separating the vascular and intracellular compartments is the intercellular or interstitial compartment, constituting the internal environment of the body, which surrounds the cells and capillaries and contains approximately 14 liters of interstitial fluid (about 15 percent of body weight). The plasma compartment (the vascular system in general and the capillary bed in particular) constitutes the medium of exchange, through which fluids pass in and out of the body, and on which the interstitial and intracellular compartments entirely depend for their

‡ Section of Physiology, Mayo Foundation.



blood supply and exchange of nutrients and wastes. It is the sole pathway by means of which nutrient substances are carried to the cells and catabolic products are carried away from them. Unless firmly held by chemical combination, this water can move freely under the influence of osmotic and hydrostatic forces. Water is the sole medium for transport of materials from one part of the body to another.

Water is absolutely essential to the life and metabolic activity of all cells. The entire purpose of the cardiovascular system, including the peripheral circulation, is accomplished by the transport of water and solutes to meet the demands of the tissues for the nutrients, including oxygen and other substances, and for the removal of waste products. Particulate matter and substances in the colloidal state which escape into the interstitial spaces are removed by the lymphatics, which eventually empty into the circulating blood.

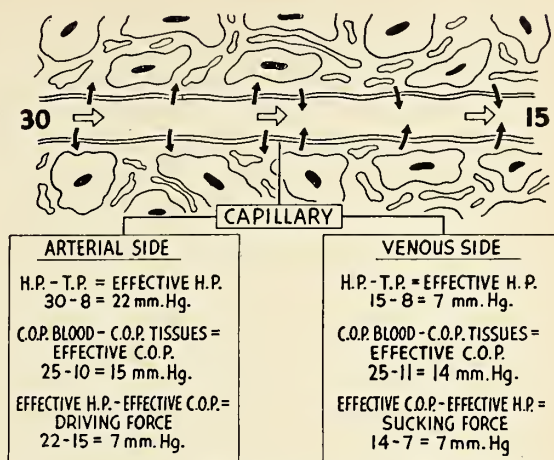
### Capillary Function

It has become an indisputable fact that the exchange of material between the blood and tissue cells, which is the entire purpose of the cardiovascular system, is accomplished by the capillaries. The discovery of how this exchange is carried on ranks in importance with the discovery of the circulation itself. It was once thought to be managed largely by a vital force residing in the capillary endothelium.

The movement of the various constituents of the fluids in the vascular and interstitial compartments is governed by certain basic factors which maintain a balanced exchange between the capillaries and the interstitial spaces.<sup>3</sup> The following are the major basic factors concerned in this balanced exchange: (1) the hydrostatic pressure; (2) the colloid osmotic pressure; (3) the semipermeability of the capillary wall and cell wall; (4) the drainage and flow of lymph; (5) tissue turgor. In addition to these major basic factors it is essential to keep in mind the role played by physicochemical equilibria of electrolytes on the two sides of the capillary and cell membranes in the regulation of this balance.

The intracapillary hydrostatic pressure and the colloid osmotic pressure in the perivascular and interstitial fluids favor the outward movement of water and diffusible substances from

Figure 1



A diagrammatic representation of the forces governing the exchange of fluids between the capillaries and tissues. The arrows indicate the direction of fluid movement. H.P. = capillary hydrostatic pressure which is about 30 millimeters of mercury on the arterial side and about 15 millimeters of mercury on the venous side. T.P. = tissue tension (pressure) which is approximately 8 millimeters of mercury. Of course this varies in different areas. C.O.P. = colloid osmotic pressure which is about 25 millimeters of mercury in the blood plasma and about 10 millimeters of mercury in the interstitial fluid. (From Wakim, K. G. and Gatch, W. D.: *Physiological Principles Governing the Normal and Abnormal Distribution of Body Fluids*. Quart. Bull. Indiana Univ. M. Center. 6:51-55 [July] 1944.)

the vascular compartment. The return of these substances into the vascular compartment and the movement of similar substances into the vascular compartment is favored by the hydrostatic pressure of the interstitial fluids and by the colloid osmotic pressure of the proteins and protein-bound substances in the plasma. The lymphatics are particularly concerned with the return of proteins from the interstitial fluids into the plasma. They provide a special route for the return of proteins and an alternate route for the return of fluid from the interstitial spaces into the vascular compartment. Starling<sup>4</sup> found that the blood proteins exert an osmotic pressure. This discovery enabled him to account completely for the exchanges in question by the opposing action of hydrostatic and osmotic forces. The hydrostatic pressure within the capillary tends to force water and solutes through its wall (filtration); and the osmotic pressure within it has the opposite effect of sucking in fluids and solutes (absorption). Filtration occurs usually through the arterial side of the capillary, where the hydrostatic pressure exceeds the osmotic pressure, and absorption occurs through the

venous side, where this relation is reversed, as shown in figure 1. The direction of flow is clearly indicated by the arrows. The resultants of forces governing the exchange demonstrate that on the arterial side of the capillary, fluid and solutes are driven out of the capillary into the tissue spaces; while on the venous side, fluid and solutes are sucked back into the circulation.

There are two extracapillary forces which affect these exchanges: (1) the osmotic pressure of the interstitial fluid, which helps filtration and opposes absorption, and (2) the hydrostatic pressure of the tissues (tissue tension), which has the opposite effects. These two forces, under normal conditions, practically neutralize one another, because they are about equal. They may have, however, under abnormal conditions, a marked effect on capillary function. The walls of the capillaries are not very permeable to protein molecules, but are readily permeable to water and solutes. Solute are so quickly diffused from the blood into the interstitial fluid that they can cause only a transient difference in osmotic pressure between the two. The ready diffusibility of crystalloids so quickly equalizes their concentration on both sides of the capillary wall that for all practical purposes they can be left out of the discussion of these forces because they exert an equal crystalloid osmotic pressure inside and outside the capillary membrane.

Rous and his associates<sup>5-10</sup> made a study of the permeability of capillaries to certain dyes. They reported observations which indicated the presence of a permeability gradient from the arterial to the venous end of capillaries. Water and crystalloids were assumed to pass much more easily through the capillary wall on the venous end than on the arterial end. In the opinion of Rous and his associates this gradient of capillary permeability is an actual property of the capillary endothelium rather than a result of changes in the blood pressure or in the blood itself.

### Regulation of Fluid Balance

As long as the previously described forces for exchange of the body fluids are within normal range and are left undisturbed, the body remains in water balance. The water, eliminated with other substances through the skin, lungs, gastrointestinal tract, and kidneys, is regularly

and adequately replenished through the sensitive mechanisms which regulate the demands of the body for food and drink. These processes account for the absence of dehydration, water intoxication, and edema when our body tissues and organs are performing their task physiologically.

However, certain disturbances may arise and offset this nicely regulated turnover of body water, so that edema or dehydration will mar the normal picture. Whenever abnormal conditions occur, a certain set of factors comes into play and brings about the changes resulting in edema.

### Edema

In an excellent presentation, Landis<sup>11</sup> summarized under two headings the factors concerned in the production of edema: (1) primary factors; (2) contributory factors. The primary factors are fundamental, since each of them in a sufficient degree of severity can alone produce clinical edema. The contributory factors do not in themselves produce edema but can modify the distribution or severity of the edema produced by the primary factors.

The following are the primary factors: (1) elevated capillary pressure; (2) lowered colloid osmotic pressure; (3) damage to the capillary wall; (4) lymphatic obstruction.

The contributory factors are the following: (1) low tissue tension; (2) high salt intake; (3) high fluid intake; (4) warm environment; (5) disturbed innervation. It is also very important to consider the fluid output in comparison with the intake.

It is not very difficult for one to find clinical examples which will substantiate each of the foregoing factors. For instance, the effect of elevated capillary pressure in the production of edema is seen in cases of venous congestion produced by a cardiac decompensation resulting in congestive heart failure. Thrombophlebitis or a tight bandage may lead to an increased capillary pressure and cause edema. Prolonged protein starvation and also nephroses will produce an edema attributable to a reduction in the colloid osmotic pressure of the blood. Injury to the capillary wall brought about by any cause is likely to lead to an increase in the permeability of the endothelial wall of capillaries



and to result in leakage of the plasma proteins into the interstitial spaces. The edema following burns, severe infections, or chemical injury can be attributed, at least in part, to damage to the capillary wall on top of a loss of plasma proteins. Recurring lymphangitis or an obstruction of the lymphatics by parasites or by cancerous tissue is likely to interfere with lymphatic drainage and lead to unilateral edema. The elephantiasis commonly observed in filariasis is a good example of lymphatic obstruction.

Tissue tension is an important but neglected factor in the pathogenesis of edema. Not infrequently the increased tissue tension after the development of edema may be the chief factor in the arrest of the progress of edema. The early edema appearing around the eyes in nephritic patients is due to the low tissue tension in the periorbital areas. For that reason experienced clinicians always try to detect incipient edema by carefully examining the loose tissues around the eyes. This is usually the first locus of edema in cases of nephritis.

The mechanism of action of a warm environment in the production of edema is brought about by the vasodilatation accompanying the rise of environmental temperature, which raises capillary blood pressure and increases the capillary area for filtration. It is a commonplace experience that during hot weather our feet are likely to get a little too large for our shoes; also, the stories told by patients who have a tendency toward edema bring out the fact that edema is worse during the hot summer months than in other seasons. This is fundamentally a change produced by the warm environment and is explainable by the previously described mechanisms.

Disturbed innervation may produce manifestations, such as the unilateral edema observed at times in cases of hemiplegia. However, disturbed innervation alone is very rarely capable of producing edema unless a primary factor is operating in a very severe degree. For that reason edema is more conspicuous in a paralyzed extremity of patients who have incipient cardiac disease than in their other extremities. In addition to the vasodilatation, which encourages filtration, the paralysis, especially the flaccid type, aids in the production of edema by abolishing muscle tone and the activity of the affected muscles, which is one of the chief factors in promoting venous return and the flow of lymph.

It has been stated that edema in nephritic patients appears first around the eyes because the periorbital tissues are loose and therefore have an extremely low tissue pressure. This early and localized edema develops before the plasma proteins are reduced by leakage through the capillaries which, as the disease progresses, become damaged by toxic agents. The agent which makes the glomerular capillaries permeable to plasma proteins, and leads to albuminuria in nephritis, will have the same effect on the capillaries throughout the entire body. The depletion of plasma proteins, chiefly albumin, leads to marked reduction of the colloid osmotic pressure of the plasma and consequently exaggerates the flow of fluid from the blood into the tissue spaces. The persistent albuminuria of nephroses or nephritis reduces the osmotic pull of the plasma proteins, their grip on intravascular water is broken and, consequently, water moves out of the lumina of the capillary bed into the tissue spaces. Edema itself is nothing more than distention or expansion of the intercellular or interstitial spaces by accumulation and the resulting increase in volume of the extracellular fluid.

Whenever a primary factor is present edema can be very quickly made apparent by administration of liberal amounts of water or by high salt intake. The salt, especially the sodium ion, is supposed to have a high affinity for water. That is why a mild restriction of salt intake is advisable in patients who are highly susceptible to the development of edema. However, the restriction of salt intake should not be to such an extreme extent as to make the patients unhappy by the unpalatability of their food, and consequently to superimpose malnutrition on a tendency toward edema. In a recent publication on postoperative salt intolerance, Collier and associates<sup>12</sup> stated that great care must be used in administering isotonic saline solution or Ringer's solution to patients who are hypoproteinemic, anemic, acidotic, or oliguric.

### Electrolyte Balance

In the past fifty years major changes have occurred in the concept of fluid and electrolyte therapy. We have learned that even though preoperatively an individual can tolerate large amounts of physiologic saline solution administered intravenously, serious complications may

develop in the same person in the immediate postoperative period if he is given a slight excess of saline solution. Evans (1911),<sup>13</sup> Trout (1913)<sup>14</sup> and Matas (1924)<sup>15</sup> reported the important observation that salt intolerance developed postoperatively. In subsequent years, however, several investigators emphasized the seriousness of salt loss and stressed the complications resulting therefrom. This culminated in an era (1920 to 1936) during which the postoperative administration of physiologic saline solution became very frequently used<sup>16-22</sup> and a "clinical rule" was established "for quantitatively replacing the depleted salt" in surgical cases. During this period the emphasis of the dangers of salt depletion influenced many surgeons to prescribe saline infusions *ad libitum* to their patients. Consequently, excessive quantities of salt were often administered, and the syndrome of salt retention and its clinical sequelae became evident.

It was not long before the pendulum swung in the opposite direction and caution was sounded against this energetic and promiscuous use of saline solution.<sup>23, 24</sup> The earlier concept came again into the foreground; namely, that postoperative patients do not tolerate the administration of excess salt solutions. This made Coller and associates<sup>25</sup> reconsider their clinical rule in the light of the new reports, and they subsequently decided that no saline solution or Ringer's solution should be given during the day of operation and during the following two postoperative days. Ariel and Kremen<sup>26</sup> made an excellent comparative study of the preoperative and postoperative distribution of sodium chloride in surgical patients. They found that in the same patients postoperatively a small amount of the chloride was present in the plasma (11.9 percent), but a much greater quantity shifted into the interstitial spaces (67.1 percent), where it was apparently retained and was not delivered to the kidneys for excretion. They noted preoperative mobilization of the proteins into the serum in response to the salt load, but this mobilization of proteins did not occur in the same subject postoperatively. They suggested that this was the factor in preoperative retention of the salt in the plasma and that postoperative failure of mobilization of proteins into the serum permitted the diffusion of chloride into the interstitial spaces.

### Relation to Plasma Proteins

There is an intimate relationship between the retention of fluid and retention of electrolytes within the circulation.<sup>27, 28</sup> Subsequent to saline infusions, Stewart and Rourke<sup>28</sup> obtained an increase in total plasma proteins. In their opinion this permits the circulation of extracellular fluid between the vascular and interstitial compartments. The report of Ariel and associates<sup>29</sup> suggested that the inability of infused saline solution to elicit mobilization of proteins into the circulation to the same extent postoperatively as preoperatively is possibly related to surgical trauma and protein depletion. The preoperative urinary concentration of chloride during the first twenty-four hours after saline infusion averaged from 114 to 143 mEq. per liter, while for a similar postoperative period it averaged only from 56 to 74 mEq. per liter. The total amount of chloride excreted in twenty-four hours preoperatively averaged 16.1 gm. of sodium chloride, while for the same period postoperatively only 9.7 gm. of sodium chloride were excreted. The older the patients, the greater was the salt retention.

### Relation to Sodium Ion

Serum sodium has a great influence on the osmotic stability of body fluids. In normalcy, the serum sodium is maintained within the narrow range of 135 to 150 mEq. per liter. The physiologic mechanisms involved in the control of this narrow range are not well understood. The kidneys handle sodium so effectively that, even though the dietary intake of sodium undergoes wide variations, only trivial changes occur in the serum sodium level. On diets low in sodium the amount of sodium excreted by the kidneys is much reduced, while as the sodium load is increased it is believed that there is a reduction in the amount of sodium reabsorbed by the kidneys. Mokotoff and associates<sup>30</sup> reported a straight-line relationship between the amount of sodium reabsorbed by the renal tubules and the sodium load. However, Black and associates<sup>31</sup> found that the amount of sodium reabsorbed by the renal tubules is not determined solely by the sodium load. They suggested that the delay in the readjustment to a normal or increased sodium load indicates that a hormonal mechanism may be concerned. The sodium



retention observed in salt-depleted subjects is attributed to an overaction of the adrenals as a whole, leading to cortical overproduction of adrenocortical hormones. The Danfords<sup>32</sup> reported that a diet deficient in sodium chloride acts as a systemic stress, causing increased production of adrenocortical hormones.

In normalcy the kidneys, under the influence of certain steroids of the adrenal cortex and other hormones, can adjust urinary excretion of sodium and water to maintain a constant concentration and total quantity of sodium in the organism. Too rapid a loss of sodium in considerable amounts may deplete the body stores and lead to circulatory collapse. Danowski<sup>33</sup> stated that any consideration of the extracellular sodium stores must be based on a three-dimensional concept. The concentration of sodium, the volume of extracellular fluid through which it is distributed, and the total amount of extracellular sodium must be taken into account in evaluating any critical situation.

In conditions of prerenal failure, such as cardiac failure, there is an increase in extracellular fluid volume accompanying the retention of sodium. The restriction of sodium intake in such conditions is a valuable practice. However, if the restriction of sodium is rigidly adhered to for a sufficiently long period to cause a severe fall in the serum sodium level it may bring about a reduction in the volume of urine excreted and cause retention of body water. There is clinical evidence for an increased retention of fluids in spite of a very low serum sodium.<sup>34-37</sup> Bristol<sup>38</sup> produced a marked delay in the excretion of administered water in both rats and dogs when the levels of serum sodium were very low. He stated that, although initial dietary restriction of sodium chloride may aid in relieving edema, the serum sodium may fall to levels that interfere with excretion of urine and lead to reaccumulation of body fluids. Signs of water intoxication can be easily elicited in states of salt depletion. Schroeder<sup>37</sup> reported that in the low salt syndrome in patients, signs of water intoxication were readily observed; these signs—namely, anorexia, vomiting, coarse fibrillary twitchings, weakness and convulsions—were easily produced by Bristol<sup>38</sup> when water tolerance tests were given to salt-depleted animals. When the serum sodium concentration was lowered, fewer doses of water were required to bring about water intoxication.

### Relation to Potassium Ion

Not only the changes in body water but also those in acid-base balance are governed by the exchanges of sodium, potassium, chloride and bicarbonate. The source of bicarbonate is chiefly metabolic, while that of sodium, potassium and chloride is primarily dietary. In the light of recent advances it is no longer correct to consider the cell membrane as impervious to sodium and potassium, nor to believe that only alterations in extracellular fluids are amenable to therapy. Recently, experimental and clinical observations<sup>39</sup> have brought forth convincing evidence that rapid changes in composition of intracellular fluids can occur and seriously upset the acid-base equilibrium of extracellular fluids. The loss of potassium upsets the function of cells. In discussing the clinical physiology of potassium Hoffman<sup>40</sup> estimated the total potassium content of the adult body to be about 4,000 mEq. (160 gm.), of which only 70 mEq. are in the extracellular fluids. This emphasizes the fact that potassium is predominantly an intracellular cation, but it should not be taken to mean that potassium cannot leave the cell. It has been clearly shown<sup>41, 42</sup> that potassium escapes from the cells during its loss from the body and enters the cells on its administration. In other words, there is a dynamic equilibrium between the low extracellular and the high intracellular concentration of potassium. The mechanisms involved in maintaining such an unstable equilibrium are not known. It is believed that cellular anoxia leads to leakage of potassium from the cells into the extracellular spaces. In exercise<sup>43</sup> and in agonal states serum potassium increases. In stored blood potassium escapes from the erythrocytes into the plasma. In rats subjected to severe potassium deficiency intestinal dilatation and failure to pass stools developed. The evidences of intestinal paralysis were relieved by administration of potassium.<sup>44</sup> In familial periodic paralysis the paralysis of skeletal muscles was accompanied by low plasma potassium and was relieved by the administration of potassium salts.<sup>45</sup> Sometimes in chronic nephritis in the absence of oliguria or anuria paralyzes appear and can be relieved by cautious use of potassium salts. The concentrations of potassium in serum and muscle were found low in such cases.<sup>46, 47</sup>

The upper limit of the normal range of extracellular potassium is about 5.5 mEq. per liter. The ingestion of potassium can temporarily increase the potassium ion concentration above this limit,<sup>48</sup> but in those whose body stores of potassium are intact, the kidneys rapidly eliminate the increments of potassium. At times the extra potassium may enter certain cells<sup>49</sup>—namely, the hepatic and muscle cells—for temporary storage; but in a matter of hours this potassium in turn re-enters the interstitial fluid and is excreted by the kidneys.<sup>50, 51</sup> Two mechanisms are concerned in the elimination of potassium: (1) glomerular filtration and (2) tubular excretion.

The presence of excess potassium ions alters cellular function. The presence of high concentrations of potassium ions in the plasma leads to prolongation of conduction time through the heart, various changes in the T wave, and finally heart block. Cardiac disturbances may begin to show up at potassium concentrations of 7 millimols per liter.<sup>52</sup> There are certain definite clinical signs and symptoms which appear in the presence of high blood potassium. According to Darrow and Pratt<sup>52</sup> the following signs and symptoms have been observed in hyperkalemia: (1) listlessness and mental confusion, (2) numbness and tingling of the extremities with a sense of weakness and heaviness of the legs, (3) bradycardia and occasionally total irregular rhythm, (4) peripheral vascular collapse and low blood pressure, (5) sometimes a rapidly ascending flaccid paralysis, and (6) cardiac arrest. The hyperkalemia usually occurs in cases with great reduction of renal function associated with oliguria in shock and dehydration. In the presence of normal kidneys and normal cardiovascular system, it is difficult to produce potassium intoxication by oral use of potassium salts.

### Kidney Function

Disturbances of electrolytes often develop in severe nephritis when the kidneys, because of pathologic changes, become unable to conserve water and begin to waste sodium, chloride<sup>53, 54</sup> and at times potassium.<sup>46</sup> The kidneys in such a state become unable to form acid urine and excrete ammonium salts to spare sodium and potassium. The wastage of sodium and potassium and the retention of phosphates, sulfates and other acids leads to metabolic acidosis. How-

ever, when severe oliguria occurs, the retention of potassium may become so marked as to cause heart block.<sup>55-57</sup> Verney<sup>58</sup> provided evidence indicating that the rate of water reabsorption by the renal tubules is under the control of the antidiuretic hormone from the posterior pituitary gland. The antidiuretic hormone brings about a reduction of urinary volume whenever there is an increase of the concentration of electrolytes in the extracellular fluids or a decrease of body water. The behavior of this hormone provides a mechanism for the regulation of the volume as well as the concentration of extracellular fluids. However, electrolyte disturbances are not usually encountered during the polyuria of diabetes insipidus, because the renal tubules function normally in their selective reabsorption to preserve the electrolyte concentrations in the blood. In adrenal insufficiency the kidneys are unable to conserve sodium.<sup>59</sup> The administration of sodium may partially restore renal function, but the retention of potassium must not be overlooked in such cases.

### Appropriate Solutions for Replenishing Body Water and Electrolytes

Consideration of appropriate solutions for replenishing body water and electrolytes follows most fittingly the discussion of the principles governing the exchange of body fluids and their maintenance with the electrolytes in dynamic stability. There are a number of solutions containing various constituents which can be given parenterally to replace body water. Glucose in 5 to 10 percent solution in water is a very effective solution for intravenous administration if the rate of injection is controlled. A slow rate of injection of 5 to 10 percent solution of glucose to replenish body needs of water and yet not to give more glucose than can be metabolized by the body at the time is often recommended. For every 100 calories metabolized, 100 cc. of 5 percent solution of glucose provide all the glucose needed for maximal sparing of proteins and for elimination of ketosis and at the same time conserve the extracellular fluid due to glucose.<sup>60</sup> It is very helpful to keep in mind that 10 percent solution of glucose is as high a concentration as can be tolerated by veins over long periods.

There are a number of appropriate solutions



for replenishing body electrolytes. Physiologic saline solution (0.9 percent sodium chloride), which is isotonic with body fluids, is the basic solution for replenishing body electrolyte. It contains the principal extracellular ions and can be easily sterilized. Isotonic saline solution contains more chloride than body fluids normally contain; consequently the mixture of two parts isotonic saline solution with one part isotonic sodium lactate (sixth molar) solution will very closely resemble interstitial fluid. Hartman's lactated Ringer's solution and an appropriate mixture of sodium chloride and bicarbonate can be made of the same composition as the interstitial fluid.

Whenever the deficit of sodium in body fluids is greater than that of chloride, an appropriate solution to use is isotonic solution of sodium lactate. Usually 70 cc. of sixth-molar solution of sodium lactate per kilogram of body weight is the maximal dose needed over a short period. Sometimes in the treatment of metabolic acidosis with excessive amounts of sodium bicarbonate or lactate, alkalosis and tetany may develop, especially if there was an uncorrected deficit of potassium. Darrow and Pratt<sup>61</sup> developed a solution called "K-lactate," which contains 4.0 gm. of sodium chloride, 2.7 gm. of potassium chloride, and 52 cc. of molar sodium lactate per liter. In order to avoid potassium intoxication this solution should be given slowly subcutaneously over a period of at least four hours to supply the dose needed for one day. Not more than 80 cc. per kilogram of body weight are needed to replace maximal deficit of extracellular electrolyte. If "K-lactate" solution is to be given intravenously it should be diluted with three parts of 5 or 10 percent solution of glucose in water. Butler and associates<sup>62</sup> suggested for intravenous use a solution which contains 5 millimols of phosphate per liter and is similar to "K-lactate" diluted with two parts of 5 or 10 percent solution of glucose in water. This solution is recommended for diabetic coma and for diarrhea. If the patient has adrenocortical insufficiency (Addison's disease, and so forth), solutions containing potassium should not be used.

In the treatment of alkalosis ammonium chloride can be given intravenously. If the alkalosis is associated with depletion of potassium as well as of sodium and chloride, a solution made up of 6 gm. of sodium chloride and 2.7 gm. of potassium chloride per liter should be

more effective than physiologic saline solution alone. It is advisable to dilute this solution with two or three parts of 10 percent solution of glucose for intravenous use.

### Routes for Administration of Fluids

There are several routes that can be utilized for the administration of fluids to replenish body water and electrolytes.

1. *Oral Route.*—This is the best and most natural route for supplying bodily needs for water and electrolytes. However, at times when patients cannot retain fluids given by mouth because of persistent vomiting, as in peritonitis or paralytic ileus, other routes have to be used. In serious surgical procedures on the gastrointestinal tract it is advisable not to use the oral route.

2. *Rectal Route.*—The most favorable feature of this route is that the solutions do not need to be sterilized. Fluid can be given by drip at the rate of 30 to 50 drops per minute. Sometimes 300 to 500 cc. over a period of four hours can be given. The major disadvantage of the rectal administration of fluids is that the quantities absorbed may be insufficient.

3. *Hypodermoclysis.*—The most undesirable feature of the subcutaneous route for administration of fluids is the discomfort associated with it. Hypodermoclysis causes pain locally, and the patient has to lie still or at least keep the part motionless during the administration. The fluids should be isotonic and at body temperature. The skin and subcutaneous tissues must not be overstretched. There is danger of sloughing of the skin and infection in the injected area. The cardiovascular system must be adequate in order to make the subcutaneously injected fluid available to the body in due time.

4. *Intravenous Route.*—This is the route most often used for parenteral fluid therapy. The only advantage is that the fluid becomes available to the body immediately. This route is indicated in conditions in which augmentation of blood volume and combat of dehydration are needed. It is used in parenteral feeding to provide calories and nourishment and also to promote immediate diuresis. Intravenous administration of fluids is contraindicated in cases of pulmonary edema, congestive heart failure with edema, hypoproteinemia and extensive renal damage.

Parenteral feeding is limited to vitamins and solutions of glucose and amino acids. Recently there has been a strong attempt at the preparation of a fat emulsion for intravenous use. In the adult about 1 gm. of protein hydrolysate per kilogram of body weight and in infants about 2.5 gm. per kilogram of body weight are needed to supply the twenty-four hour requirements. A mixture of 2 gm. of amino acids in 225 cc. of 10 percent solution of glucose yields about 100 calories. Such a mixture provides the caloric requirements and the water needed for each 100 calories metabolized.

5. *Intraperitoneal Route.*—This is used occasionally, but in the hands of those who advocate peritoneal lavage in cases of uremia it is used frequently.

### Parenteral Fluid Therapy

In many phases of medical management, especially in the postoperative care of surgical patients, there arises frequently a need for parenteral fluid therapy. Subcutaneous administration of fluid is not well tolerated, and the intravenous route is most frequently utilized.

The most practical procedure for giving fluids to supply the daily requirements of body water is the intravenous drip of the appropriate solution. It has been demonstrated that postoperatively the kidneys tend to conserve both water and salt.<sup>63</sup> This explains the interest expressed by some in limiting the intake of water and salt in the immediate postoperative period when the volume of urine is small. Between 90 and 125 cc. of water are needed for each 100 calories metabolized. Roughly the daily needs for water can be estimated at 1 cc. per calorie. The water and electrolyte requirements can be supplied by giving, out of every 100 cc., 10 to 20 cc. of isotonic saline solution or "K-lactate" and the rest as 5 or 10 percent solution of glucose in water.

In profound circulatory collapse and shock the transfusion of blood or plasma is very helpful in replenishing blood volume and the oxygen-carrying capacity of the blood. However, in the absence of whole blood or plasma, the infusion of about 30 cc. of physiologic saline solution per kilogram of body weight is sound practice. In the presence of metabolic acidosis the use of a mixture containing one part isotonic

solution of sodium lactate and two parts isotonic solution of sodium chloride is better than use of solution of sodium chloride alone. In metabolic alkalosis, solution of sodium chloride alone is better but the intravenous use of calcium chloride or gluconate is recommended.

In states of severe dehydration, the loss of water and electrolyte in infants can be restored by use of 80 cc. of the appropriate solution per kilogram of body weight. In adults 70 cc. is sufficient. It might take about six days to replace the deficit, because it will take at least that many days for the cells to make adjustments for the deficiency. In addition to the deficiency of sodium chloride there is often a deficiency of potassium. There is no need for giving more than 3 mEq. of potassium (0.22 gm. of potassium chloride) per kilogram of body weight in most conditions.

### Summary

The physiological factors governing the normal exchange of body water and electrolytes between the cells, the blood vessels and the tissue spaces in the living organism are explained. In the normal organism the fluids and salts in the body are maintained in a dynamically stable equilibrium by the interaction of various factors on the intaken water and salts. The regulation of the output of water and the various constituents resulting from metabolic activity throughout bodily tissues is carried out in a very precise manner by the kidneys, gastrointestinal tract, lungs, and skin, which are the excretory organs of the body and the avenues for the normal excretion of bodily wastes and surpluses of water and salts. As long as the factors governing this exchange and the organs for excretion are acting and interacting normally, the living body remains free of edema due to accumulation of fluids in the tissue spaces, and of dehydration due to deprivation of the body of its water, or its salts or both.

The importance of various substitutes for blood and body water and salts is explained. These substitutes and the indications and contraindications for their use in medical and surgical conditions before and after operation are stressed. The difference in the handling by the body of fluids and salts before surgical opera-



tions as compared with after operation is presented. The promiscuous use of fluids post-operatively is condemned. When to give, as well as when not to give fluids and salts by the blood stream to the severely ill surgical and medical patients, are emphasized. Nutritive solutions

for parenteral use are presented and the value of each constituent is discussed.

The bibliographic references have been omitted from *THE JOURNAL* because of lack of space; however, they are included in the author's reprints.

## SOME PRACTICAL ASPECTS OF FLUID AND ELECTROLYTE BALANCE

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THE restoration and maintenance of fluid and electrolyte balance in a patient is based on an estimation of the type and extent of deficit from the history and physical examination with some supplementary information obtained from laboratory tests. Many times there is a tendency to rely solely on the laboratory when actually data obtained in this manner may be normal in the face of serious disturbances of total body concentration.<sup>1,2</sup> Frequently the clinical picture is as good an index of the underlying problem as the usual laboratory determinations, although in many instances these are indispensable.

Determination of the basic problem and etiology is essential. Equally important is the information concerning the type and quantity of oral and parenteral fluid which has been received, as well as the type and quantity of fluid lost by all channels. This is particularly important if the patient requires gastrointestinal suction and must be maintained on parenteral fluids, but it applies to any situation in which there is a fluid or electrolyte imbalance. The

actual signs and symptoms vary as to whether there is a deficit or an excess of either water and/or electrolyte. However, in the evaluation of the patient one can generally consider that a disturbance in the volume of the extracellular fluid tends to produce manifestations in the circulatory system and that a disturbance in the volume of intracellular fluid tends to produce qualitative changes in both the neuromuscular apparatus and central nervous system (disorientation, tremors, delirium, belligerency).<sup>3</sup>

Arbitrarily the various aids in the maintenance of fluid and electrolyte equilibrium can be divided into those primarily concerned with water balance and those primarily concerned with electrolyte balance. However, it must be remembered that fluid and electrolyte balances are interrelated and that seldom is there an alteration in only one.

### Daily Weight

One of the simplest aids in following the fluid balance of a patient is his daily weight. This

is obtained in the morning, after voiding, before eating and drinking, and with the same amount of clothing being worn at each weighing. A portable bathroom scale can be used, but one should examine its accuracy since in some scales the shifting of weight from one foot to the other may alter the reading several pounds. Daily weighing can be carried out in most medical fluid problems, such as cardiac decompensation, hormone therapy, and can frequently be obtained in surgical cases. This gives a sensitive index of fluctuations in total body water, but tells us nothing about shifts of water and electrolytes into cells or into serous cavities. An important adjuvant in the management of severe problems is an intake-output sheet or chart which will work. This is especially true if the patient is receiving Wangenstein suction, has a gastrointestinal fistula or has an extensive burn. To appreciate the orderly tabulation of fluids taken in and put out, one need only attempt to determine the state of fluid balance in such a patient by collecting the scattered and frequently ambiguous recordings in the nurses' notes of a hospital chart.

### Intake-Output Chart

An example of an intake-output chart that appears to work and is being used at Memorial Hospital is seen in Fig. 1. One advantage of this type of chart is that the record is broken down into eight hour intervals which coincide with the changing of nurses. In this way the nurse responsible for the patient checks the fluid record before leaving the floor, and as a reminder to do so a therapy card such as many hospitals use to check the narcotic supply can be made. Also, discussion with the nursing staff of the problem and its importance as well as exactly what you want done usually assures their cooperation. Food, if it can be taken by mouth, is regarded as 100 percent water but the water content of formed stools is disregarded. An estimation of perspiration is made, since if there is no fever or sweating, there is a loss of about 1000 ml. of water each 24 hours due to insensible loss. However, with sweating and temperature elevation, the water loss may be 2000 ml. or more as well as a considerable loss of sodium chloride. Scribner has developed a bedside test for chloride<sup>4</sup> in all body fluids in order to maintain chloride balance as well as

Figure 1

MEMORIAL HOSPITAL  
of  
SOUTH BEND

INTAKE AND OUTPUT RECORD

Name		Hosp. #				Physician				
Date		7-3	3-11	11-7	7-3	3-11	11-7	7-3	3-11	11-7
Intake	Oral									
	Lavage									
	Fluid									
	Parenteral									
TOTAL										
Output	Urine									
	G.I.									
	Suction									
	Perspiration									
TOTAL										
Balance										

Intake and Output Record

water balance.<sup>5</sup> Actually in a private, non-teaching hospital one does well to keep an accurate record of the fluid intake and output of the patient and uses means other than chloride balance to keep the patient's electrolytes at an approximate equilibrium.

### Urinary Excretion

Another consideration is the volume and specific gravity of the urine. With adequate concentrating power of the kidney, at least 500 ml. of urine must be excreted per day in order to eliminate the normal urinary waste products of about 35 grams, with more urine being needed if there is renal impairment. However, if the volume of urine per day exceeds 2500 ml. (or 100 ml./hr., if a catheter is in place), excessive water intake is usually present, especially if the patient is being maintained on parenteral fluids. Cope and Moore<sup>6</sup> have used the hourly output of urine following the intravenous infusion of approximately 1000 ml. of fluid in a relatively short period of time (40-60 min.) as a means of differentiating between renal shutdown and inadequate fluid therapy in burn patients with oliguria (0-30 ml./hr.). If a clear-cut increase in hourly urine output occurs, one may assume that the kidney is still functioning adequately,



but that the fluid therapy is inadequate. On the other hand if there is no increase in the urine output, one should be cautious and not overload the patient with fluid in the face of impending renal shutdown. The specific gravity is of importance in oliguria since if glucose and protein are absent, a high specific gravity usually means dehydration while a low specific gravity which approaches 1.010 means renal shutdown, usually lower nephron nephrosis. Also, a fixed specific gravity in the neighborhood of 1.010 when a patient is dehydrated is perhaps the best and easiest obtained index of severe renal impairment. The presence of acetone in the urine is frequently associated with a sodium and chloride deficiency such as is seen in diabetic acidosis or in prolonged vomiting due to duodenal obstruction. However, the acetonuria in the latter is due to starvation ketosis and is associated with a metabolic alkalosis and an elevated  $\text{CO}_2$  combining power (serum bicarbonate). In other words, acetonuria is not always an indication of acidosis being present.

### Urinary Chloride

The determination of the amount of chloride excreted in the urine is of value in the diagnosis of salt depletion and as a guide for therapy, providing the patient has normal kidney function and does not have adrenal-cortical insufficiency. The amount of chloride in the urine may be determined by the mercuric nitrate bedside method of Scribner or by the silver nitrate method of Fantus,<sup>7</sup> which is just as reliable in protein-free or low protein fluids, and just as simple if there is a laboratory nearby where the test can be carried out. We use a modification of the Fantus test by using 1 ml. pipettes with 0.1 ml. graduations so that drops are replaced by 0.1 ml. quantities of urine and reagents. Our own experience with urine chlorides indicates that the morning urine specimen is the most reliable but that they have a limitation of usefulness in the immediate postoperative period. This is somewhat in accord with Reimers and Zollinger<sup>8</sup> who have stated that if the morning specimen of urine contains less than 3 grams of chloride as sodium chloride/liter of urine, there is salt depletion present. In the urine specimen selected at random, the critical level of chloride is closer to 1 gram/liter especially in the immediate postoperative period. However, this actually meas-

ures chloride and not sodium, which is much more important in the overall fluid and electrolyte equilibrium. While sodium and chloride are usually excreted together in the urine, Randall et al.<sup>9</sup> have found that such is not always the case in seriously ill postoperative patients where the true state of affairs is most important.

### Blood Constituents

Hemoglobin and hematocrit levels, as well as serum protein concentrations, will be lowered in water intoxication; in an acute state of dehydration there is an elevated concentration of these blood constituents. However, many cases of water deficit which have developed over a considerable period of time and are associated with an electrolyte deficiency have relatively normal hemoglobin, hematocrit, and serum protein values, because frequently the mechanism that has induced the water deficit is also lowering the total concentration of these substances. If there is an inadequate fluid intake and a subsequent oliguria, the level of nitrogenous waste products goes up in the blood. In this situation (extrarenal azotemia) the creatinine level may be elevated in proportion to the increase in blood urea and does not have the serious prognostic importance as when seen in chronic glomerulonephritis. Also, the transitory elevation of the blood urea following gastrointestinal bleeding and absorption of the digested blood proteins must be differentiated from either of these conditions.

### Electrolyte Levels

The electrolytes of the body are in solution and in the form of ions. Their concentration may be expressed in terms of weight per unit volume (usually as milligrams per 100 milliliters—mg/100 ml.) or in terms of chemical equivalence (or combining power) as milliequivalents per liter—meq/L. The latter is more desirable since the various elements vary in weight, and concentrations expressed in weight per unit volume do not indicate their chemical significance in relation to other electrolytes. The concentration of the ions in terms of mg/100 ml. is easily converted to milliequivalents/liter by the formula:

$$\frac{\text{Concentration (meq/L)} = \text{Concentration (mg/100 ml)} \times 10}{\text{atomic weight}} \times \text{Valence.}$$

Figure 2

NORMAL VALUES OF ELECTROLYTES AND  
FACTORS CONVERTING mgm/100 ml to meq/L

	Normal mgm/100 ml	Factor	Normal meq/L
Na +	317-340	0.435	137-148
K +	16-21	0.257	4.1-5.4
Ca ++	9-11	0.500	4.5-5.5
Mg ++	1.2-2.4	0.833	1-2
HCO <sub>3</sub> (CO <sub>2</sub> /Vol. %)	55-75	0.455	25-34
Cl(as NaCl)	585-645	0.171	100-110
(as Cl)	352-389	0.286	100-110
PO <sub>4</sub> =	3-5	0.58	1.7-2.9
SO <sub>4</sub> =	1.6-2.4	0.625	1.0-1.5
Protein(Gm. %)	6.5-8.0	2.43	16-19

Conversion of milligrams per 100 ml to milliequivalents per liter.

$$\text{Concentration (meq/L)} = \frac{\text{Concentration (mgm/100 ml)} \times 10}{\text{atomic weight}} \times \text{Valence}$$

Factor converting concentration in mgm/100 ml to meq/L =

$$\text{Factor} = \frac{10}{\text{atomic weight}} \times \text{valence}$$

\*does not apply to HCO<sub>3</sub><sup>-</sup>, PO<sub>4</sub><sup>=</sup>, and protein.Normal Values of Electrolytes and Factors Converting  
mgm/100 ml to meq/L (adapted from Ham<sup>10</sup>)

Figure 3

South Bend Medical Foundation, Inc.  
531 N. Main St., South Bend 1, Indiana  
ELECTROLYTES

## Serum

Sodium(as Na+) mg% \_\_\_\_\_ meq/L \_\_\_\_\_  
 Potassium(K+) mg% \_\_\_\_\_ meq/L \_\_\_\_\_  
 Calcium(Ca++) mg% \_\_\_\_\_ meq/L \_\_\_\_\_  
 Bicarbonate(HCO<sub>3</sub><sup>-</sup>)vol% \_\_\_\_\_ meq/L \_\_\_\_\_  
 (CO<sub>2</sub>Combining Power)  
 Chloride(as Cl-) mg% \_\_\_\_\_ meq/L \_\_\_\_\_  
 Phosphate(as P) mg% \_\_\_\_\_ meq/L \_\_\_\_\_  
 pH(venous) \_\_\_\_\_

## Urine

Volume/24hr \_\_\_\_\_ ml \_\_\_\_\_  
 pH \_\_\_\_\_ Sp. gr. \_\_\_\_\_  
 Sodium(as Na) gm/L \_\_\_\_\_ meq/L \_\_\_\_\_  
 Potassium(as K) gm/L \_\_\_\_\_ meq/L \_\_\_\_\_  
 Chloride(as NaCl) gm/L \_\_\_\_\_ meq/L \_\_\_\_\_  
 gm/24hr \_\_\_\_\_

By \_\_\_\_\_

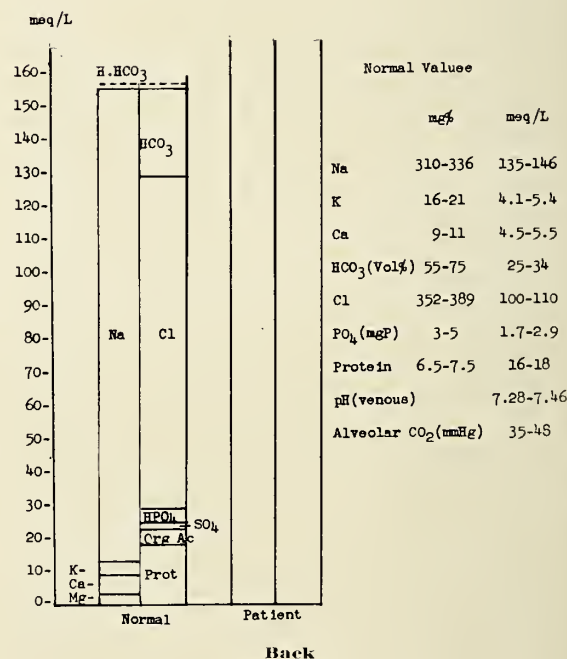
Patient \_\_\_\_\_ Room \_\_\_\_\_

Doctor \_\_\_\_\_ Date \_\_\_\_\_

Front

In order to facilitate the conversion of mg/100 to meq/L by technicians, we use a factor for each ion which is calculated from the above equation.<sup>10</sup> (Fig. 2.) The electrolytes are reported to the clinician in the South Bend Hospitals in both mg/100 and meq/L on a special electrolyte form. (Fig. 3.) On the back of this form are the normal values and a graphic representation of the normal serum electrolytes as well as a skeleton figure in which the clinician may plot the values for his patient if he wishes.

The serum sodium concentration is of aid in the diagnosis of a low salt syndrome, in Addison's disease, and in cases of less severe electrolyte deficiency. An increase in the serum sodium concentration is almost invariably a sign of dehydration and if the patient is conscious, is accompanied by thirst. However, the diagnostic value of the serum concentration of this substance is diminished since the body so zealously guards the osmotic constancy of its fluids. Consequently, in such disease entities as cirrhosis and in cardiac decompensation where there is an increase in total body sodium, the serum sodium is low or normal because of the secondary water





retention in order to maintain osmotic equilibrium. Actually the serum sodium concentration can be roughly estimated from the sum of chloride and bicarbonate concentrations provided that acetonuria is absent, and that renal function is not seriously impaired.

The determination of serum potassium concentrations is of value in the diagnosis of either elevated or diminished total body concentrations of this substance. However, the levels obtained must be interpreted with the rest of the clinical picture. This is particularly true since the concentration of potassium in the cells of the body is approximately forty times that in the serum and consequently the serum value may not reflect the total body concentration. As an example, dehydration and shock may concentrate the serum potassium so that a false high value may be obtained.

### Electrocardiograph

A solution to this problem has been suggested by the use of electrocardiograms. Some people<sup>11</sup> feel this is a better index to the intracellular potassium concentration than the serum potassium concentration, but this assumption is open to question. Although the electrocardiogram is not a substitute for the chemical estimation of this ion, it is a valuable adjuvant, especially if facilities for doing the chemical determinations are not available. Hyperpotassemia is first manifested by tall narrow T waves, then by widened QRS complexes, and finally by auricular arrest with no P waves.<sup>12</sup> The electrocardiographic changes in hypopotassemia have been summarized by Bellet et al.<sup>13</sup> and consist of depression of the ST segment, low amplitude and inversion of T waves, prolongation of the QT interval (usually best seen in the precordial leads) and a prominent U wave. Although the QT interval varies with the heart rate, at average rates it is less than one-half the R-R interval and this can be used as a rough upper limit of normal. In addition to these changes we have also found numerous premature contractions in patients with low serum potassium levels which have disappeared when the potassium deficit was repaired. However, it must be remembered that all of these electrocardiographic changes may be seen in other clinical states and must be differentiated from those changes seen in myocardial damage of various types, effect of drugs,

especially quinidine. Nevertheless, the electrocardiogram gives a rapid and fairly reliable index of presumed hypopotassemia when interpreted with the remainder of the clinical picture and is an adequate means of regulating the amount of therapy after the diagnosis has been established. The colorimetric estimations of serum sodium and potassium are fairly long procedures, taking approximately 1½ to 2 hours. The use of the flame photometer has cut this time down to about 10 minutes, but unfortunately, this instrument is only available in a few laboratories. For either method in the potassium determination the serum should be separated from the clot within a half hour, with no hemolysis, in order to avoid a shift of this ion from the red blood cells which have a higher concentration than the serum.

### Acid-Base Balance

The maintenance of acid-base balance is intimately tied in with fluid and electrolyte equilibrium. The disorders of the acid-base balance can be divided into two general groups, metabolic or respiratory, depending on whether the primary disturbance as reflected in the carbonic acid/bicarbonate buffer system is the bicarbonate ( $\text{CO}_2$  combining power) due to a metabolic disorder or the carbonic acid as the result of a primary disorder of the respiratory mechanism. In the metabolic disturbances which comprise the majority of acid-base disorders encountered, the  $\text{CO}_2$  combining power is a valid index of the state of affairs of the body's acid-base balance. As an example, in diabetic acidosis the  $\text{CO}_2$  combining power is depressed before the body's buffer systems are no longer adequate and the plasma pH starts to fall. However, in the respiratory disorders of acid-base balance, the  $\text{CO}_2$  combining power is elevated before the serum pH starts to fall in respiratory acidosis (pneumonia, emphysema) and is depressed before the serum pH starts to rise in respiratory alkalosis (hyperventilation). Consequently a plasma pH determination is necessary in order that a true picture is obtained in the respiratory or mixed disorder. The pH of the urine may be of aid in some of these respiratory disorders in which there is a discrepancy between the  $\text{CO}_2$  combining power and the plasma pH since changes in urine pH tend to follow the same direction as changes in the plasma pH. (Fig. 4.)

Figure 4

	BLOOD pH	CO <sub>2</sub> COMBINING POWER	URINE pH
METABOLIC ALKALOSIS	↑	↑	↑ Up To 7.8
RESPIRATORY ALKALOSIS	↑	↓	↑
METABOLIC ACIDOSIS	↓	↓	↓ Down To 4.5
RESPIRATORY ACIDOSIS	↓	↑	↓

Relationship of pH of blood and urine and CO<sub>2</sub> combining power (bicarbonate)

However, these changes in the urine pH can be altered by renal failure and severe electrolyte shifts such as a severe potassium deficiency so that they may be of little aid.

There is a reciprocal relationship between the serum chloride and bicarbonate (CO<sub>2</sub> combining power) which must be taken into consideration when either is evaluated alone. If one uses the graphic representation of serum electrolyte concentration, expressing their concentration in milliequivalents/liter this reciprocal relationship is more evident, since as an anion the serum chloride decreases when the CO<sub>2</sub> combining power increases and vice versa. It should be remembered also that a severe metabolic alkalosis associated with hypochloremia and hypoproteinemia is frequently due to a potassium deficiency, and only after the latter is remedied do the other electrolyte and acid-base alterations return to normal. At times it is the secondary acid-base disturbance that leads to the diagnosis of an electrolyte deficiency; as an example, if an alkalosis with a CO<sub>2</sub> combining power above 60 volumes percent persists in a patient with vomiting after adequate hydration and sodium chloride therapy, a potassium deficiency should be suspected.<sup>14</sup> We have seen several cases of potassium deficiency which were recognized after a hypochloremic alkalosis was found and in which the correction of this deficit was life-saving.

### Summary

In summary, the maintenance of fluid and electrolyte balance in a patient is dependent on the

history, physical signs and an accurate record of the fluid intake and output with laboratory data serving as a valuable aid. Of equal importance is an understanding of the basic mechanism by which the disorder has developed and by which the deficit can be repaired and equilibrium maintained.

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## FLUID AND ELECTROLYTE BALANCE— MEDICAL APPLICATION

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WITH the advent of constant low sodium diet therapy and the frequent use of diuretics, new hope and comfort have been given to the patient in circulatory failure due to heart disease. Unfortunately, in the occasional patient this type of management results in distressing complications. Schroeder<sup>1</sup> is usually credited with being one of the first to publish a series of cases describing what he has chosen to call, "low salt syndrome." Eleven of his twenty original cases were discovered in retrospect—after the patients had died.

### Low Salt Syndrome

It has been fairly well established that mercurial diuretics act by preventing the reabsorption of sodium chloride from the filtrate passing by the convoluted renal tubules.<sup>2</sup> This action of mercurials results in a salt diuresis that is accompanied or followed by a water diuresis. Occasionally the anticipated diuretic response fails to appear following the injection of a mercurial. When this occurs, the patient should be immediately suspected of developing a "low salt syndrome." The clinical status of the patient changes. There is drowsiness, weakness and lethargy. Anorexia is usually quite marked and is often accompanied by nausea and vomiting. There may be distressing abdominal and muscle cramps. There may be other symptoms attributable to increase in extracellular fluid. Clinical signs and findings are evidenced by decrease in urinary volume to the point of anuria; decreased urinary chlorides; rapid weight gain; elevation of the blood nonprotein nitrogen; decrease in plasma sodium chloride and increased cardiac rate. As pointed out by Schroeder, the

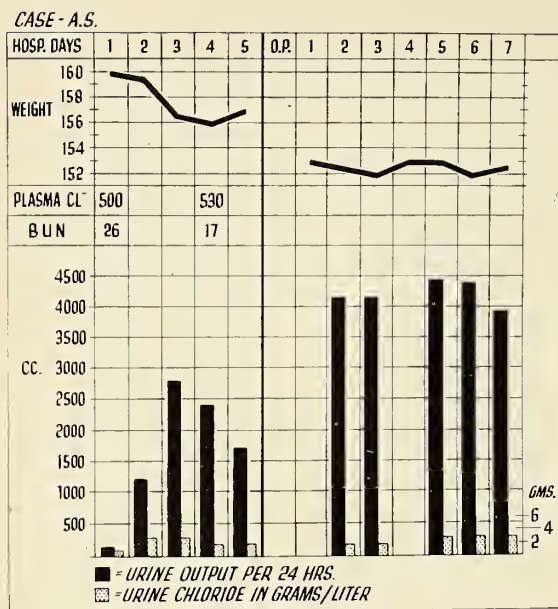
syndrome can be initiated by the depletion of sodium chloride from the body through the use of mercurial diuretics; by overhydration and subsequent dilution of remaining sodium chloride. Other circumstances can produce the above sequence of events. An example is prolonged Wangensteen suction in a patient getting quantities of non-salt-containing fluids parenterally.

### Case No. 1

The following is a brief case summary of a white female, age 51, who had aortic insufficiency due to syphilis and who when first seen was in severe circulatory failure. Treatment consisted of low sodium diet, digitalization, and diuresis, using ammonium chloride and mercurials. Her response was excellent. Approximately two weeks after her discharge from the hospital, she was readmitted because of weight gain, a one-day history of oliguria, nausea and vomiting, plus profound weakness and calf muscle tenderness. She had been taking ammonium chloride for three days before the onset of symptoms. Blood studies on admission (figure 1) revealed a plasma chloride of 500 mg.%, normal being 560-620 mg.%. The blood urea nitrogen was 26 mg.%, normal being 15-18 mg.%. Her urine output, which was 200 cc. for the first 24 hours, contained less than 1 gram of sodium chloride as determined by the Fantus test. She was then given 15 grams of sodium chloride as a 5 percent solution intravenously. The following day she was given 9 grams of salt orally with the result of a diuresis at the end of the third day of almost 3000 cc. of urine containing 2½ grams of sodium chloride per liter. The diuresis resulted in a 4 pound weight loss and alleviation of all symptoms. Blood studies repeated on the fourth day revealed a

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Figure 1



plasma chloride of 530 mg.% and a normal blood urea nitrogen. This patient has been instructed in how to accomplish urine chloride studies in her home using the simple Fantus test. The second portion of the slide shows approximately a week's record kept by her. She has found that so long as she excretes 3500-4000 cc. of urine daily containing approximately 2 grams of salt per liter as determined by Fantus study that she gets along very well, as is evidenced by a stable weight record. She still requires a mercurial approximately every 10 days to two weeks which results in a large water and salt diuresis. On occasions she has required the oral administration of 4-6 grams of salt the day following mercurial injection because of the onset of abdominal cramps and calf muscle ache. On the above program she is able to take care of a small home.

### Case No. 2

The second case is that of a 71-year-old white female admitted by her physician 5-2-51. She was known to have arteriosclerotic heart disease and to be in circulatory failure. She had been on a program of digitalis, low salt diet, and bi-weekly injections of mercurial. Because the edema had failed to respond to this program, her physician admitted her for more extensive treatment. The nurses' notes state that at the time of admission she was "cheerful and lively."

Physical findings confirmed gross evidence of circulatory failure due to probable arteriosclerotic heart disease. The blood pressure was 112/70; pulse, 88. The complete hemogram was normal. A catheterized urine specimen revealed a specific gravity of 1.010; albumin, .9%; 2+ WBC; 4+ RBC; there were no casts. A blood study revealed that the albumin-globulin ratio was reversed, the total albumin being 2.3 grams percent, and the globulin being 2.7 grams percent. The admitting orders consisted of low salt diet, .2 mg. Crystodigen daily, 1 gram of ammonium chloride four times daily, daily weight record, and 2 cc. of mercurial daily. Requested special laboratory studies will be presented. By the fourth hospital day it was noted that the patient was drowsy. She developed diarrhea and abdominal cramps. Nausea was marked. On the eighth hospital day she was confused and apprehensive. She started to vomit. The course was gradually downhill and two days later she lapsed into a comatose state and died. Postmortem findings revealed that the heart weighed 450 grams. There was an old occlusion of the left anterior descending branch of the coronary artery as well as Grade 2 sclerosis of the remaining coronary vessels. Microscopically, there was Grade 2 fibrosis of the myocardium. The kidneys evidenced intimal sclerosis and the glomeruli showed extensive fibrosis, approximately 50 percent being destroyed by the process.

This, then, is a case of acidosis and possible "low salt syndrome" in a patient with arteriosclerotic heart disease and arteriosclerotic renal disease. Low salt syndrome is suggested by the failure to respond to diuretics and rapid weight gain in the presence of a low salt diet and a rising blood nonprotein nitrogen. Urinary output records were not available. The acidosis was produced by the constant administration of ammonium chloride. The acidosis produced by ammonium chloride is no different from any other acidosis.<sup>2</sup> The constant administration of ammonium chloride results in a continuous loss of fixed base as is evidenced by the progressive lowering of the CO<sub>2</sub> combining power (figure 2).

That dehydration is not part of the clinical picture of low salt syndrome is evidenced by the large stores of fluid in these patients. It is difficult to produce an acidosis in normal patients



Figure 2

C # 15078

Hour, Day	Daily Urine	Mercurial 2 cc.	NH <sub>4</sub> Cl 4 gm.	I.V. FLUID	N P K me. %	Blood NaCl me. %	CO <sub>2</sub> G/L
1	151	X	X		61	500	50
2	151	X	X				
3	155	X	X	250 cc. PLASMA			
4	154		X	250 cc. PLASMA			
5	153	X	X	250 cc. PLASMA			
6	152	X	X		125	500	49
7	152	X					
8	153		X	500 cc. 10% GLUCOSE			
9	153		X	500 cc. 10% GLUCOSE			
10			X	500 cc. 10% GLUCOSE WITH 4 GMS. NaHCO <sub>3</sub> 1000 cc. 1/6 M. Na LACTATE	200	470	17
11			X	500 cc. 10% GLUCOSE WITH 4 GMS. NaHCO <sub>3</sub> 1000 cc. RINGER'S			
12		EXITUS					

by administration of even large quantities of ammonium chloride; however, in circulatory failure where there is frequently associated renal disease, or at least renal malfunction, it is quite readily produced. This clinical point is frequently forgotten. In this patient the progressively lower CO<sub>2</sub> combining power is evidence of acidosis. In low salt syndrome without acidosis, the CO<sub>2</sub> combining power may be normal or even elevated. Another point that must be kept in mind is that because mercurials produce a greater diuresis of chloride than they do of sodium, a point is reached in some patients where there exists a hypochloremia, that is, abnormally low plasma chloride, and a normal or elevated plasma sodium.<sup>3</sup> This, then, represents a metabolic alkalosis in the presence of a hypochloremia. In this circumstance there would again be a lack of diuresis following injection of mercurials. However, the administration of ammonium chloride here would immediately result in a diuresis. Fortunately, these complications are not frequent but it behooves the clinician to be on constant guard.

### Primary Renal Disease

Let us next turn to the problems of electrolyte balance in the patient manifesting primary renal disease. In the circumstances that produce acute renal shutdown, it is generally agreed that the amount of fluid administered should be limited to 750-1000 cc. a day, plus the amount lost in diarrhea and vomiting.<sup>4</sup> Little can be accomplished by trying to "break through" the acute anuric state by flooding the body with isotonic glucose. Overhydration in such a circumstance may produce convulsions. In the anuric state, frequent determinations of the plasma chlorides, potassium, and CO<sub>2</sub> combin-

ing power are essential. Moderate depression of plasma sodium chloride may be of benefit in that it aids in maintaining a lowered blood pressure. If there is excessive chloride loss through vomiting and diarrhea, further urinary depression may occur. If sodium chloride need be replaced, it should be given orally if possible; otherwise, intravenously in small amounts in a 3 to 5 percent solution. Acidosis can be controlled at times by the oral administration of food alone. If necessary, soda bicarbonate, 6-10 grams a day, can be given by the intravenous route. It must be remembered that in acute anuric states there frequently occurs hyperpotassemia which in itself may cause death. The administration of ion exchange resins to fix the potassium in the bowel may be of value here. If the anuric state is prolonged, some type of artificial dialysis is indicated. In proper hands the artificial kidney has proved most successful. Peritoneal lavage and intestinal dialysis are formidable procedures. They, too, have their advocates. However, most recoverable anuric states can be conservatively handled by a diet extremely low in sodium and high in fat and carbohydrate. The diet should total approximately 2500 calories per day. No protein is allowed. Borst<sup>5</sup> has demonstrated the protein sparing effect of a high caloric diet, thus reducing urea formation to as little as 2-5 grams per day. By contrast, 20-30 grams of urea are produced per day by individuals eating a normal diet.

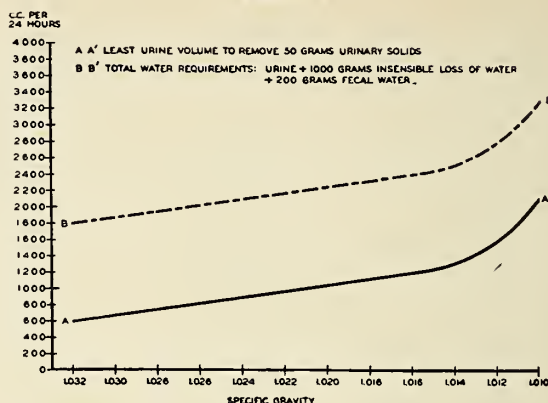
### Chronic Renal Disease

In the patient with chronic renal disease, the most frequent problem is that of trying to keep the patient edema free. The edema is usually due to a lowered blood protein—particularly albumin with a resulting imbalance of osmotic forces. However, the organism is unable to retain fluid unless the fluid is accompanied by a fixed amount of sodium.<sup>6</sup> Thus it is necessary for the body to retain 3.3 grams of sodium for each liter of water that it retains. Therefore, if the sodium in the diet is restricted to the amount that totals that lost through the skin and feces, plus the amount that the diseased kidneys are capable of excreting, net increase in extracellular fluid is not possible. By the same token, if by the use of acidifying salts, sodium can be removed, water will necessarily have to follow in the proportion of 1 liter for each 3.3

grams of sodium eliminated. Unfortunately, acidifying salts have rather marked limitations. Nothing will be accomplished by restricting fluid since fluid cannot be retained without sodium. On the other hand, large volumes of water increase urine volume and because of dilution make reabsorption of the sodium from the filtrate more difficult. Nephritic urines are dilute as is evidenced by a low specific gravity. They remain dilute even though the amount of available water is limited. The large volume of urine should be regarded as compensatory in its attempt to remove urea with the least amount of work. Newburg<sup>6</sup> has worked out an interesting graph (figure 3) showing what amounts of 24-hour urine are necessary to eliminate 50 grams of solid waste at a given fixed specific gravity. Line A-A shows the minimal urinary volume in relation to the specific gravity achieved by the individual. In the normal person, a urine volume of 600 cc. is sufficient, while in the nephritic, four times that amount is necessary. Curve B-B shows the least amount of water required by these various persons to avoid dehydration. This curve is constructed by adding an additional 1000 cc. for insensible water loss plus 200 cc. for fecal water.

The management of ascites in the patient with cirrhosis of the liver and hypoproteinemia presents much the same problem as in the patient with edema due to chronic renal disease. Remember that fluid cannot be retained without salt. Therefore, the same rule attends the patient with cirrhosis as attends the edematous patient with chronic renal disease and edema due to hypoproteinemia. The daily intake of sodium

Figure 3



must be limited to that amount lost in the sweat and feces, plus the amount that the kidneys are able to eliminate; 3.3 grams of sodium (140 mEq.) must be retained in order to retain 1 liter of fluid.

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**RURAL HEALTH MAKES NEWS.** More than 500 medical and farm leaders gathering in Denver for the Seventh Annual Conference on Rural Health made news. The Conference's theme—how to help rural communities help themselves to better health—was carried not only in many newspapers and magazines but also to a large radio audience in the Denver area and throughout the midwest.

Over 35 different radio programs—arranged by the Colorado State Medical Society and the AMA Public Relations Department—were broadcast. Tape recordings of the entire Conference are being edited down into six 15-minute programs entitled, "Help Yourself to Health," which will be available to medical societies from the AMA's Bureau of Health Education.



# FLUID BALANCE AND SODIUM CHLORIDE

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*Indianapolis*

**S**ODIUM CHLORIDE has long been recognized as an active part of the body's metabolism. It not only constitutes a major portion of the body's soluble salts, but is closely integrated with all the other salts of the body. Realization of this interdependency of the salts has caused many discussions of the problem in recent years.

The overall picture of normal sodium chloride metabolism is rather crudely indicated in diagram I. Here it will be noted that the average adult has in his body roughly 100 grams of sodium chloride. Of this, one-fifth or 20 grams is in the plasma. It will also be noted that normal supply and replacement of the body's salt is by daily oral intake of 5 to 15 grams. The amount of salt which the body retains is zealously guarded by the kidneys. These organs normally filter 5 to 10 grams of salt daily. Should the intake stop or the body reserve reach

subnormal levels, the kidneys immediately stop filtration. This ability on the part of the kidneys to conserve normal body sodium chloride is not shared by some of the other salts, such as potassium chloride.

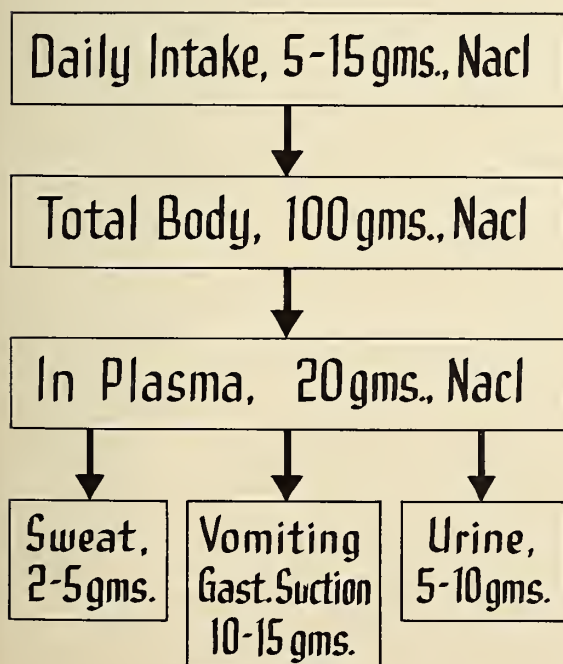
Under normal conditions the balance indicated is a very simple one. It will also be noted that the above condition may become quite abnormal should vomiting become prominent. Vomiting not only allows a possible loss of 15 grams of sodium chloride daily but prevents the normal oral intake of this salt. If it were not for the guarding action of the kidneys and parenteral salt replacement, it is obvious that a very serious salt loss might ensue which might be incompatible with life in two or three days.

It must be emphasized that all patients who have had an anesthetic have an abnormal fluid-electrolyte balance. Therefore, practically all postoperative surgical patients are abnormal in this respect. True, the abnormal phase may last but an hour or day and usually corrects itself. If it continues for a longer time it behooves the surgeon to replace the lost salt and water. If the type of operative procedure is one like a gastric resection, where normal salt and water intake is prevented for days and even a week or more, the problem becomes complicated. Intake must be calculated and replacement carefully watched for the body has lost many of its automatic controls and must depend on the surgeon's estimate of the particular needs.

## Gastric Aspiration

The frequent use of postoperative gastric suction demands some thought as to its effect on water salt balance. There has been no single advance in the entire surgical field which can match the general acceptance of the nasal-gastric suction tube. With its use have disappeared the postoperative distentions, postoperative vomiting and many other postoperative complications.

Diagram I



But with it has come a responsibility and danger which is often not appreciated. It is a two-edged sword which can deplete the body of chlorides just as quickly and far more insidiously than active vomiting. The same amounts of chlorides are removed quietly through a plastic tube as may be vomited projectilly into an emesis basin.

In order to determine the amount of chloride removed with the usual nasal-gastric suction we have made a number of determinations on relatively normal pre-operative patients. For the most part these were patients undergoing study prior to the gastric surgery for peptic ulcer. A few had lesser complaints. So far some forty patients were studied at the Indianapolis Veterans Hospital to determine the amount of chloride lost each 24 hours by gastric suction.

We were also interested in a closely allied phase of this problem. This involves the usual custom of allowing water *ad lib.* by mouth in the thirsty patient with the nasal-gastric tube in place. It is the contention of those who follow this practice that only a given amount of chloride is produced in the stomach and that only this amount can possibly be removed. It is further stated by this group that swallowed water does not augment this loss and that the washing effect of this swallowed water is negligible. This part of the problem was carried out on the same patients previously mentioned.

The procedure followed is indicated in diagram II. In part one of the test with a nasal-gastric suction tube in place nothing was allowed by mouth for 24 hours. Approximately normal hydration was maintained with 3,000 cc. of 5 percent glucose intravenously. In a representative 24 hour test the gastric suction amounted to 1900 cc. and this contained 11 grams of chloride

(chloride expressed as sodium chloride). The urinary chloride loss during this same 24 hour period was 2.5 grams. This total chloride loss is large (13.5 grams). Few actively vomiting patients would lose so much in a day. Yet this loss takes place quietly through a valuable therapeutic adjunct, constant gastric suction.

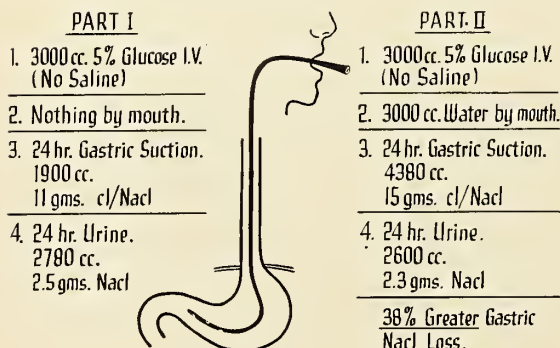
After a rest of a day the patient was subjected to part two of the analysis. The test was run in exactly the same manner, with the exception that the patient swallowed moderate amounts of water to a total of 3000 cc. Care was taken to make sure the tube was open and that the swallowed water was promptly aspirated. In the representative test over 4000 cc. of gastric washings were removed and this contained 15 grams of chloride (expressed as sodium chloride). The urinary output was about the same as part one and contained 2.3 grams of chloride. In the example given the total of chloride lost in part two by gastric suction (15.8 grams) was 38 percent greater than that lost in the patient who was allowed *nothing* by mouth.

We are not finished with our study but so far the results indicate a third greater chloride loss in patients allowed water *ad lib.* by mouth over those who are allowed none. This difference is not large and in the average case should cause little trouble. However, in the critical case this increased loss may be sufficient to tip the scales adversely and result in calamity.

Water is usually allowed by mouth to the patient with a gastric tube because the patient complains of thirst. This is not necessary. If the patient is properly hydrated intravenously with 5 percent glucose or even distilled water he will have little discomfort from thirst even though he receives not a drop of water by mouth. Our moral is obvious—water by mouth is to be avoided when using gastric suction.

The clinical signs of sodium chloride deficiency or excess are not outstanding. Stewart and Rourke<sup>1</sup> have indicated that normal persons may retain an excess of 12 grams of this salt without showing edema. On the other hand it has been pointed out in our studies and those of others<sup>2,3</sup> that normal patients may lose 10 to 15 grams of sodium chloride without clinical signs of deficiency. This wide range suggests the difficulty of anticipating an early change from normal. How then is the salt balance in the postoperative patient maintained? What

Diagram II





precautions must be taken to prevent a dangerous imbalance?

Perhaps the most important factor in balance is the ability of the average patient to rid himself of excess salt or to conserve it when necessity demands. Certainly with most of our surgical patients this is sufficient. Patients who can eat, balance themselves; the others require help. This postoperative fluid balance takes several forms which may be divided into three general patterns. These are as follows:

(1) The most simple means (and likewise least reliable) is to estimate the sodium chloride lost each day and replace this amount parenterally. Unless the patient is losing fluids by vomiting, the normal requirement is covered with 500 cc. of saline daily. If the patient is vomiting or is subjected to gastric aspiration an added amount of saline must be given. Roughly, half the amount of fluid lost by this route is given back to the patient in the form of parenteral saline. The remainder of the patient's fluid requirement is made up of glucose solution. It should be noted that normal kidneys are capable of secreting many times the indicated salt intake. It is therefore the custom to give considerably more than half a liter of saline.

(2) The second plan includes the features of the foregoing estimation but adds to it numerous checks on plasma sodium and chloride. To this has recently been added an adaptation<sup>3</sup> of the Fantus<sup>5</sup> test. This consists of a rapid bedside titration of the urine chloride against a standard (2.9 percent) silver nitrate solution. A urine chloride level of 3 grams (NaCl) per liter is considered critical. If the test indicates a level above 3 grams no additional salt is necessary, but if there is less than this amount of salt, more is given in the parenteral fluids.

This revival of the Fantus test has become quite popular in some institutions. Because of this, certain warnings and shortcomings must be mentioned in connection with it. Recently Johnson<sup>5</sup> has emphasized that patients develop a suppression of urinary sodium chloride excretion postoperatively. This is a normal and expected event supposedly associated with the elaboration of adrenal steroids. The Fantus test in these patients indicates a deficit considerably lower than the true situation and leads to excessive administration of salt. A second source of error occurs when the test is run immediately after the administration of intravenous glucose.<sup>6</sup>

Thus, after giving a liter of 5 or 10 percent glucose the urinary sodium chloride frequently drops below the critical level (3 grams). The excretion returns again to normal levels with the passage of time. Again, the test may lead to errors in those cases of hypochloremic alkalosis in which the abnormality can be corrected only by the administration of potassium, not sodium chloride. If these pitfalls are fully appreciated, the Fantus test is of considerable value.

(3) A third method is based primarily on the accurate measurement of the patient's intake and output of chloride. By this means the intake of salt and water can be adjusted to equal the output or loss. This is facilitated by the bedside titration of all excreta. Those factors taken into consideration in calculating output of fluid and chloride include urine, gastric aspiration or vomitus, loose stools and insensible fluid loss. The method sounds cumbersome, but is carried out rapidly by a technician making the rounds of fluid balance patients.<sup>7</sup> The only other altered routine is the instruction of the nursing staff in saving and properly labeling all intake and output.

Additional checks on the plasma chlorides are also carried out but the necessity for these become far less frequent if a careful water-salt balance is maintained. It must be emphasized that any water balance study should start before the patient (and surgeon) gets into trouble. Except for emergencies, the patient who is apt to have trouble can be anticipated beforehand. This group certainly includes all those undergoing gastrointestinal surgery and therefore these patients should be on a balance study from the beginning.

It is quite impossible to divorce the study of sodium chloride from other associated electrolytes and the entire acid-base problem. We cannot study one electrolyte without studying and understanding the others. It is absurd to consider sodium chloride as a mass of salt crystals dissolved in plasma. On entering the blood stream it becomes dissociated into sodium and chloride ions, each acting independently. These chemical activities have definite potentialities and limitations which are well known, and for the most part their actions can be accurately predicted.

Therefore, it is high time that we stop considering the various electrolytic salts as so much dead weight measured in ounces on the grocer's

scales. The electrolytes are active elements and we must evaluate them on their chemical activity. The activity of the salt, not its grams weight, must become our common denominator. To do this and to understand the actual chemistry of fluid balance is to talk in terms of milliequivalents.\*

Mention of the term milliequivalent strikes awe in the average practitioner and horror in the surgeon. Yet, there is nothing awesome or mysterious about the term. It is a simple and logical designation of chemical activity. There is nothing new about it—we understood it well in medical school under perhaps slightly different phrasing. Why then is there such general rebellion against its use?

It seems to the writer that if as much time had been spent in trying to understand milliequivalents as we surgeons, at least, have spent in trying to resist this innovation, the problem would now be well in hand. We must stop our guesswork and accept scientific reasoning. We must familiarize ourselves with underlying chemistry of fluid balance. Only by so doing can

we form any scientific basis for treating imbalance and be able to treat the patient whose balance is in a hazardous state and whose life may rest on our decisions.

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\* A discussion of milliequivalents follows.

#### ALUMNI DAY—MAY 14, 1952

Dwight H. Murray, M.D., Napa, California, chairman of the Board of Trustees of the American Medical Association and one of the distinguished graduates of the Indiana University School of Medicine, will be the principal speaker at the Medical School's fifth annual Alumni Day, Wednesday, May 14.

In an address to be presented in the auditorium of the School of Medicine at 3 o'clock in the afternoon, climaxing the Alumni Day activities, Doctor Murray will discuss, "The Relationship Between the American Medical Association and the American Medical Colleges." A native Hoosier, Doctor Murray graduated from the former Central Normal College at Danville and taught for several years before receiving his M.D. degree from Indiana University in 1917. He has been a leader in the AMA for a number of years.

Also on the afternoon program for Alumni Day will be Dean John D. VanNuys' annual report to the alumni, on the subject, "What Comes Next?" The annual business meeting will be conducted by Dr. Will C. Moore, Muncie, president.

The day's activities begin at 9 o'clock on May 14 with registration at the Laboratory Science building, followed by sightseeing bus trips over the campus, visits to the hospitals and informal gatherings. The traditional picnic lunch will be served on the campus at noon, during which reunions will be held for all classes whose numerals end in '2' or '7'.

In charge of the class reunions are: 1907-Roy Egbert, M.D., Indianapolis, secretary; 1912-Clyde C. Bitler, M.D., Newcastle, chairman, George W. Bowman, Indianapolis, secretary; 1917-Venice D. Keiser, M. D., Indianapolis, chairman, Karl L. Koons, M. D., Indianapolis, secretary; 1922-Edward M. Pitkin, M.D., Martinsville, chairman, Donald Durman, M.D., Saginaw, Michigan, secretary; 1927-Frank B. Ramsey, M.D., Indianapolis, chairman, Byron K. Rust, M.D., Indianapolis, secretary; 1932-Olga B. Booher, M.D., Indianapolis, chairman, Palmer O. Eicher, M.D., Indianapolis, secretary; 1937-Donald J. Caseley, M.D., Chicago, chairman, James L. Sims, M.D., Indianapolis, secretary; 1942-(May)-Helen VanVactor, M.D., Indianapolis, chairman, Theodore Schlaegel, M.D., Indianapolis, secretary; 1942-(Dec.)-James Logan, M.D., Richmond, chairman, Charles E. Kime, M.D., Richmond, secretary; 1947-Thomas A. Stump, M.D., Indianapolis, chairman, Joseph S. Bean, M.D., Indianapolis, secretary.



# THE MILLIEQUIVALENT AS A UNIT OF MEASURE IN CALCULATING ELECTROLYTE DEFICIENCIES IN BODY FLUIDS

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THE diagnosis and treatment of disturbances in electrolyte and fluid balance are unduly complicated if the physician uses milligrams percent, volume percent, or grams per 100 cc. to express electrolyte concentration. When these units are employed the necessary information regarding the physiological significance of the various components may not be apparent. The weight of a substance may tell little about its chemical behavior. A system of measurement expressing the chemical equivalence of each component of the body fluid is recommended in the management of electrolyte deficiencies.

Equivalence has been ably explained by Newburgh,<sup>1</sup> who says: "Imagine these solutions: One gram molecule, that is, the weight in grams corresponding to the molecular weight, of NaOH, KOH and HCl, have each been dissolved in enough water to make 1 liter. The molecular weights are, for NaOH,  $\text{Na} = 23 + \text{OH} = 17 = 40$ ; for KOH,  $\text{K} = 39 + \text{OH} = 17 = 56$ ; for HCl,  $\text{H} = 1 + \text{Cl} = 36 = 37$ . So the three solutions, each precisely one liter in volume, will contain, respectively, 40 grams of NaOH, 56 grams of KOH and 37 grams of HCl. Solutions containing 1 gram molecule of a substance are called molar solutions, and they contain one mole of the substance. When equal volumes, say 1 cc. of the alkaline NaOH solution is mixed with 1 cc. of the acid HCl solution, they neutralize each other. The same result is obtained when 1 cc. of the alkaline KOH solution is mixed with 1 cc. of the HCl solution. The two alkaline solutions show the same combining power or the same activity for

equal volumes. Each contains the same number of active particles per unit volume, but the weights of the substances per unit volume are not the same. Since 1 mole of NaOH exhibits the same combining power as 1 mole of KOH, they are 'equivalent' mole for mole. Hence 1 equivalent of any of the three substances is 1 mole of the substance. It is evident that the comparison of the two alkalies in terms of their equivalence brings us much closer to what we want to know about their presence in living systems than does the comparison in terms of weight. Carrying this conception a step further, it is evident that 1 atom of Na is equivalent to 1 atom of K or H. That is, 1 equivalent of Na = 23 grams, of K = 39 grams, of H = 1 gram.

"Substances react also on the basis of their valence. The chemicals mentioned thus far are all univalent. But Ca (atomic weight = 40) is bivalent, that is, 1 mole of Ca, which is 40 grams, possesses twice the combining power of 1 mole of Na. Hence 1 mole of Ca is 2 equivalents of Ca, or 40 grams of Ca is equivalent to  $2 \times 23$  grams of Na, and 1 equivalent of Ca weighs 20 grams."

The unit of measure is a milliequivalent, which is 1/1000 of an equivalent. Under normal conditions the extracellular fluid (the plasma plus the fluid that surrounds each cell—the interstitial fluid) contains approximately 155 mEq./l. of cations—base ions which bear a positive electrical charge, and an equal number of anions, acid ions, which bear a negative charge.

The average concentration of each electrolyte as reported by Gamble<sup>2</sup> is presented in Table 1. All of the components shown in the table

From the Lilly Laboratory for Clinical Research, Indianapolis General Hospital.

TABLE 1  
*Electrolyte Composition of Blood Plasma*

(Cations) <sup>+</sup>	(Anions) <sup>-</sup>
Base ions mEq./liter	Acid ions mEq./liter
Na' ----- 142	HCO <sub>3</sub> ' ----- 27
K' ----- 5	Cl' ----- 103
Ca" ----- 5	HPO <sub>4</sub> " ----- 2
Mg" ----- 3	SO <sub>4</sub> " ----- 1
	Organic acids ----- 6
	Protein ----- 16
155	155

except protein are readily diffusible into the interstitial fluid so that with the exception of protein the concentration of these ions in the fluid surrounding the cells is the same as that in the plasma. The table also illustrates the advantages of expressing the concentration of all components in the same unit so that the total concentration of cations and anions can be obtained. This is the chief advantage of the system of measurement based on chemical equivalence. It should also be noted that the total concentration of cations must always equal that of the anions.

Milligrams per 100 cc. can be converted to milliequivalents per liter by using the following formula:

$$\frac{\text{mg. per 100 cc.} \times 10}{\text{atomic weight}} \times \text{valence} = \text{mEq./l.}$$

Example: 360 mg./100 cc. chloride =

$$\frac{360 \times 10}{35} \times 1 = 103 \text{ mEq./l.}$$

Factors which simplify this conversion are given in Table 2. The factors for converting volume percent and grams of protein are of special importance. For their derivation the reader is referred to the syllabus "Chemical Anatomy, Physiology and Pathology of Extracellular Fluid," by Gamble.<sup>2</sup>

The usefulness of milliequivalents in planning the treatment of electrolyte and fluid imbalance is illustrated by the following examples:

I. *Estimating the Amount of Solution Necessary to Return the Electrolyte Concentration to Normal*—If it is assumed that the extracellular fluid volume is 20 percent or 1/5 of the body

TABLE 2  
*Factors for Converting Blood Chemistry Values to Milliequivalents per Liter*

	Divide by	or Multiply by
Calcium Mg. % -----	2	0.5
Chlorides Mg. % (from Cl). -----	3.5	0.286
(from NaCl) -----	5.8	0.172
CO <sub>2</sub> Vol. % -----	2.22	
Magnesium Mg. % -----	1.2	0.833
Phosphorus Mg. % -----	1.7	0.58
Potassium Mg. % -----	3.9	0.257
Protein Gm./100 cc. -----		2.43
Sodium Mg. % -----	2.3	0.435
Sulphur Mg. % -----	1.6	0.625

weight, the following formula can be used as a rough guide for determining the amount of each ion needed for replacement therapy:

$$\frac{\text{amount of ion needed (in mEq.)}}{\text{patient's wt. in kg.}} = \frac{\text{normal value of ion in mEq./liter} - \text{patient's level in mEq./liter}}{5}$$

Example: A patient weighing 154 pounds is found to have a concentration of 132 mEq./l. of sodium in the plasma. How much physiological saline must be given to provide sufficient sodium so that the concentration of this element in the plasma and interstitial fluid is restored to normal?

### Calculations

To convert pounds to kilograms, divide the patient's weight by 2.2

$$\therefore \frac{154}{2.2} = 70 \text{ kg.}$$

The average normal concentration of sodium (Table 1) is 142 mEq./l, and the patient's plasma level for this ion is 132 mEq./l. Substituting in the formula above:

$$\text{amount of ion needed} = \frac{70}{5} (142-132) = 140 \text{ mEq.}$$

Physiological saline contains 155 mEq. of sodium per liter

$$\therefore \frac{140}{155} = 0.9 \text{ liter, or 900 cc. of physiological}$$

saline to replace deficit.



II. *Estimating the Deficiency of Cations When only the Concentration of Anions in Extracellular Fluid is Available*—The amount of chloride, the carbon dioxide content and the serum protein level are known.

Example: A patient weighing 114½ pounds (52 kg.) has suffered an abnormal loss of 3 liters of intestinal and gastric fluid by siphon drainage. The hematocrit is 55; CO<sub>2</sub> content is 50.6 volume percent, and chloride 308 mg./100 cc. Total protein is 7.44 gm./100 cc. By using the factors in Table 2 these values may be converted into milliequivalents.

CO <sub>2</sub> of 50.6 ÷ 2.2	= 23 mEq./l.
Chloride 308 ÷ 3.5	= 88 mEq./l.
Protein 7.4 × 2.43	= 18 mEq./l.
From Table 1, estimation of } phosphate, sulfate and organic acids	} = 9 mEq./l.
Total anion concentration	
	138 mEq./l.

155 — 138 = 17 mEq./l. deficiency of anions. As previously stated there must be an equilibrium between anion and cation concentration in the plasma; therefore in this case there is also a deficiency of cations. Since sodium (Table 1) comprises the bulk of ions bearing a positive charge and would be the element most likely to be lost in greatest concentration from intestinal fluid, we can assume that there is also a deficiency of sodium in the plasma. On this basis, if the total base deficit of 17 is subtracted from 142 (normal sodium concentration in plasma) an approximate value can be obtained for the estimation of sodium deficiency.

142 mEq. — 17 mEq. = 125 mEq. (estimated concentration of the sodium in the extracellular fluid).

III. *Calculating the Quantity and Composition of the Solution Needed to Restore Electrolyte Concentration in the Case Cited Above—*

52

— = 10.4 liter average volume extracellular fluid.

10.4 × 142 = 1477 mEq. sodium (total amount that should be present)	
7.4 × 125 = 925 mEq. sodium (amount of sodium estimated as present when 3 liters of fluid have been lost)	

552 mEq. sodium (total deficit)

10.4 × 103 = 1071 mEq. chloride (total amount that should be present)	
7.4 × 88 = 651 mEq. chloride (amount of chloride estimated as present when 3 liters of fluid have been lost)	
410 mEq. chloride (total deficit)	

Each liter of physiological saline contains 155

mEq. of chloride ∴ — = 2.64 liters of physiological saline needed to provide 410 mEq. of chloride.

Administration of this solution would also supply 410 mEq. of sodium. However, the estimated deficit of sodium was 552 mEq. Therefore, 552 mEq. — 410 mEq. or 142 mEq. of sodium from another source must be added. Since it is not desirable to increase the concentration of anions, a preparation should be used that contains sodium in combination with an anion that can be metabolized. One of the best solutions for this purpose is 1/6 molar sodium lactate. A molar solution of sodium lactate would supply 1 mEq. of sodium per cc. and 6 cc. of a 1/6 molar solution would be needed to provide 1 mEq. of this ion. Therefore, 142 × 6 = 752 cc. of 1/6 M sodium lactate would be needed to make up the deficiency of sodium in the case under discussion.

For practical purposes the estimated quantities of repair solution can be rounded off. So, in this patient, 2.5 liters of physiological saline and 750 cc. of 1/6 molar sodium lactate would furnish enough fluid and electrolyte to repair the deficiency. Obviously the large quantity of solution should be given by slow intravenous infusion.

The examples given are intended to illustrate the use of milliequivalents in adjusting fluid and electrolyte imbalance. The quantities determined by these calculations are for replacement of the immediate deficiency and do not provide for losses through kidneys, lungs and skin.

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# THE JOURNAL

## OF THE

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## CRASH INJURY RESEARCH

A SPECIAL program by the Indiana State Police to study the factors involved in highway fatalities is now being extended to cover the entire state. The study was originally begun in 1950 on a small scale. Since then it has been expanded gradually and has been promising enough to warrant a careful state-wide program.

Preliminary findings indicate that (1) The force of many accidents now fatal is well within the physiological limits of survival, and (2) Needless injuries, both serious and fatal, are caused by the placement and design of equipment and furnishings.

The research has attracted national interest. It is being followed closely by the National Research Council (part of the President's Highway Safety Committee), the National Safety Council, several universities and safety organizations. The Indiana program will coordinate activities with the Crash Injury Research section of Cornell University Medical College.

Engineers and physicians of Cornell University are cooperating in the analysis of stress factors and physical injuries.

Special study will be made of each passenger in rural highway accidents which produce one or more fatalities. Reliable medical data are necessary. For this purpose simple report blanks as illustrated are being supplied, and the cooperation of physicians is requested.

The report form has been simplified as much as possible. Only the medical facts that have been proven to be of significance are included. The report does not require a signature and no obligation for testimony in court is created thereby in the case of the doctor who completes it.

Preliminary findings indicate that the program may provide the basis for many improvements in the safety of vehicles and their operation. This is an opportunity for the medical profession to assist in a life-saving endeavor which has been so ably organized by our State Police.



CCIR-AU-1

### INDIANA STATE POLICE AUTOMOTIVE ACCIDENT-INJURY REPORT

MAIL TO: INDIANA STATE POLICE, CRASH INJURY RESEARCH DIV., STOUT FIELD, INDIANAPOLIS 21, IND.

SECTION 1. TO BE COMPLETED BY POLICE OFFICER

NAME OF INJURED PERSON \_\_\_\_\_

ADDRESS (NO.) \_\_\_\_\_ (STREET) \_\_\_\_\_ (CITY OR TOWN) \_\_\_\_\_ (STATE) \_\_\_\_\_

ACCIDENT LOCATION \_\_\_\_\_ (ROAD NAME OR NUMBER) \_\_\_\_\_ (COUNTY) \_\_\_\_\_

DATE AND TIME OF ACCIDENT (MONTH) \_\_\_\_\_ (DAY) \_\_\_\_\_ (YEAR) \_\_\_\_\_ (HOUR) \_\_\_\_\_ (AM OR PM) \_\_\_\_\_

CHECK MARK (✓) SEAT OCCUPIED BY THIS PERSON

DRIVER (LEFT FRONT) ☐ CENTER FRONT ☐ RIGHT FRONT ☐

LEFT REAR ☐ CENTER REAR ☐ RIGHT REAR ☐

SECTION 2. FOR USE BY PHYSICIANS OR MEDICAL OFFICERS HAVING CHARGE OF PERSONS INJURED OR KILLED.

MEDICAL DATA WILL BE ANALYZED BY CRASH INJURY RESEARCH SECTIONS OF THE INDIANA STATE POLICE AND OF THE DEPARTMENT OF PUBLIC HEALTH AND PREVENTIVE MEDICINE AT CORNELL UNIVERSITY MEDICAL COLLEGE.

PURPOSE: TO PROVIDE AUTOMOTIVE ENGINEERS WITH DATA WHEREBY CAUSES OF NEEDLESS AND EXCESSIVE INJURIES DUE TO WINDSHIELDS, STEERING WHEELS, ETC., CAN BE MODIFIED BY SAFETY DESIGN.

INSTRUCTIONS

FIRST, CHECK (✓) AREAS OF INJURY IN APPROPRIATE BOXES BELOW FOR INDIANA STATISTICAL STUDIES.

SECOND, INDICATE SITE AND NATURE OF INJURIES ON ANATOMICAL FIGURE ON PAGE 2, AND COMPLETE PAGE 3 FOR CORNELL CRASH INJURY RESEARCH.

	NON-DANGEROUS (FATALITIES ETC.)	DANGEROUS*	DANGEROUS**	FATAL***
1. HEAD.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. NECK.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. CERVICAL SPINE.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. CHEST.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. DORSAL SPINE.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. BACK.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. ABDOMEN.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. LUMBAR SPINE.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. PELVIS.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. BUTTOCKS/PERINEUM.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. UPPER EXTREMITIES.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. LOWER EXTREMITIES.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NOTE: MORE THAN ONE BOX MAY BE CHECKED PER BODY AREA.

NOTE: \* NON-DANGEROUS: INJURIES WHICH NORMALLY DO NOT THREATEN LIFE.  
 \*\* DANGEROUS: INJURIES THREATENING LIFE EVEN UNDER PROMPT MEDICAL CARE.  
 \*\*\* FATAL: NON-SURVIVABLE INJURIES.

PAGE 1

SECTION 2. (Cont'd.)

FOR USE BY PHYSICIANS OR MEDICAL OFFICERS HAVING CHARGE OF PERSONS INJURED OR KILLED.

PATIENT'S APPROXIMATE HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ AGE: \_\_\_\_\_

IF INJURIES WERE FATAL WITHIN 24 HOURS, PLEASE STATE PROBABLE CAUSE OF DEATH AND SIGNIFICANT AUTOPSY FINDINGS, IF ANY:

IF INJURIES WERE SURVIVED FOR MORE THAN 24 HOURS, GIVE GENERAL DESCRIPTION OF PATIENT'S CONDITION, DEGREE OF SHOCK, T., B., P., ETC., AND STATE ANY SUBSEQUENT DEVELOPMENTS OF UNUSUAL NATURE, INCLUDING EVIDENCE OF INTERNAL INJURY.

IF HEAD INJURIES WERE SUSTAINED, STATE PERIOD OF UNCONSCIOUSNESS (IF ANY) \_\_\_\_\_ AND INDICATE DEGREE OF CONCUSSION: MILD ( ) MODERATE ( ) SEVERE ( )

THIS REPORT BASED ON OBSERVATIONS MADE DURING WHAT PERIOD AFTER ACCIDENT: \_\_\_\_\_

WHERE INJURED PERSON WAS OBSERVED: \_\_\_\_\_

DATE OF REPORT: (MO.) \_\_\_\_\_ (DAY) \_\_\_\_\_ (YEAR) \_\_\_\_\_

TREATMENT ADMINISTERED BY:

☐ FAMILY PHYSICIAN  
☐ HOSPITAL PHYSICIAN  
☐ OTHER PHYSICIAN  
☐ HOSPITAL ATTENDANT  
☐ CORONER  
☐ OTHER \_\_\_\_\_

(PLEASE STATE TITLE)

PAGE 3

SECTION 2. (Cont'd.)

FOR USE BY PHYSICIANS OR MEDICAL OFFICERS HAVING CHARGE OF PERSONS INJURED OR KILLED.

GRAPHICALLY INDICATE LOCATION AND TYPE OF INJURIES (SEE SAMPLE ON BACK PAGE).

LEFT

REAR

RIGHT

PAGES 2 & 3 MEDICAL DATA FOR SAFETY STUDIES BY CRASH INJURY RESEARCH DEPARTMENT OF PUBLIC HEALTH AND PREVENTIVE MEDICINE, CORNELL UNIVERSITY MEDICAL COLLEGE, ILL. N. Y.

PAGE 2

SAMPLE

Fracture, right ribs 4, 5, 6  
 Massive right Hemothorax with collapse of right lung  
 Severe contusion overlying liver.  
 Incomplete transverse fracture, rt superior pubic ramus.  
 2" laceration, medial aspect, rt thigh.

Compound comminuted fracture left parietal and orbital bones with displacement (depression). Same comminution.  
 1" laceration, left supra-orbital ridge.  
 Simple fracture, left humerus.  
 Compression fracture L-2.  
 Simple fractures, transverse processes, L-2 to L-5

Comminuted fracture, right acromioclavicular joint.  
 2" deep avulsion laceration, right buttock.

LEFT

REAR

RIGHT

NOTE: THIS FORM DEVELOPED BY CRASH INJURY RESEARCH AT CORNELL UNIVERSITY MEDICAL COLLEGE. IN CONSULTATION WITH MEMBERS OF THE STAFF OF THE NEW YORK HOSPITAL-CORNELL MEDICAL CENTER NEW YORK, N. Y.

PAGE 4

## AMERICAN RED CROSS

WHEN hostilities began in Korea in June 1950 the American Red Cross was operating 44 regional blood centers throughout the United States. These centers were functioning as blood banks and were devoted entirely to supplying civilian needs.

In August 1950 the Red Cross resumed its World War II task of furnishing whole blood for shipment to the combat zone. Originally the regional blood centers obtained blood for overseas use. During the first few months refrigerated blood was obtained and shipped at the rate of 10,000 pints per month.

Later 15 Red Cross defense centers were opened in areas not previously served by regional blood centers. The defense centers obtain blood for the military and civil defense program; regional blood centers perform this function and also serve as blood banks for civilian purposes. A part of the expenses for the military part of the program is paid for by the Department of Defense.

In addition to adding the defense centers the Red Cross has provided 121 mobile units and two railroad donor cars. Thirty-three cooperating non-Red Cross blood banks are assisting in the defense blood collection. Three regional programs will soon be opened and two railroad cars added.

This magnificent cooperative enterprise collected 1,430,000 pints of blood for the Department of Defense, and nearly 1,966,000 pints for civilian use in the 17-month period ending January 31, 1952. In addition 328,500 pints were provided for defense by the cooperating blood banks.

A total of 1,798 chapters of the Red Cross are participating in the program. Success in meeting all quotas and in building up reserves of blood products has been made possible by the cooperation of thousands of volunteer workers and many thousands of donors. American business, industry, community organizations, and the medical profession have assisted. Nation-wide information has been dispensed unstintingly by all the publicity agencies.

This typically American program, organized largely on a volunteer basis, is one in which we

may all take pride. It has been organized quickly and efficiently. It has depended upon and received the support of millions of Americans. The American Red Cross and all the cooperating individuals and organizations may take a bow for a job well done.

## INDIANA CHAPTER S.A.M.A.

THE students of Indiana University School of Medicine participated in the formation of the Student American Medical Association a little over a year ago. Since then they have organized their student medical society and have been constituted as the Indiana Chapter of the S.A.M.A.

The medical profession of the state and the faculty of the medical school have been represented in this auspicious undertaking. Cleon Nafe, M.D., is representing the Indiana State Medical Association, and J. O. Ritchey, M.D., is representing the Indianapolis Medical Society on the Advisory Committee.

Frank Gastineau, M.D., and Edward Shrigley, M.D., represent the faculty, and Robert Garrett, M.D., is the personal representative of Dean Van Nuys on the same committee.

The Indiana Chapter membership now totals about 300 students. A. Glenn Shoptaugh, Jr., is chapter president, Joe Ebbinghouse serves as vice-president, Nelson Gaddy is secretary, and Byron Lingeman is treasurer. Miss Jacqueline Schaefer was the official delegate to the national convention in December 1951 and was elected to the national executive committee at that time. Miss Schaefer is also vice-chairman of the national committee on conventions.

The program of the student society has been planned to advance its objectives of contributing to the welfare and education of medical students and of familiarizing its members with the purposes and ideals of the medical profession.

A meeting is planned each month, with a guest speaker. Nonscientific subjects related to the study and practice of medicine will be discussed.

Contemplated activities include an SAMA sponsored recreational and athletic program, information bureau on internships, externships and



summer jobs, and promotional work for the *Journal of the SAMA*. Interclass and faculty-student relations will be studied with a view to improvement if indicated.

Special attention will be devoted to integration of the first-year class at Bloomington with the remainder of the student body. Plans are being formulated for the publication of a monthly Student Bulletin which will be of considerable assistance in this part of the program, and will aid in disseminating information to the entire school.

The officers of the Indiana Chapter have expressed their appreciation to the members of the State Association for the interest which has been evidenced in their new organization. They will appreciate any interest and assistance which may be forthcoming in the future.

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An editorial appearing in the April 12 issue of *THE JOURNAL* urges physicians to take a more active interest in the Reed-Keogh bill, a voluntary pension plan now pending in Congress.

Under terms of the bill, the Federal Internal Revenue Code would be amended to enable self-employed professional persons and some employed persons to exclude from current taxable income amounts sufficient to finance a reasonable retirement annuity. They would, of course, have to declare the annuity as it is received during their retired years as taxable income.

The editorial said that each self-employed professional man should urge his Congressman to follow closely this bill, on which the House Ways and Means Committee has decided to hold hearings.

The American Medical Association, the American Bar Association, the American Dental Association and other groups have banded together to support this voluntary plan, rather than have the Social Security Act extended to cover them. Members of the leftist Physicians Forum in New York have gone all out in a campaign to have doctors included under social security.—*AMA Secretary's Letter*.

Mr. James A. Waggener, Executive Secretary  
Indiana State Medical Association  
1021 Hume Mansur Building  
Indianapolis 4, Indiana

Dear Mr. Waggener:

As you may or may not be aware, the Federal Civil Defense Administration's regional offices are authorized to employ full time medical directors to handle medical civil defense problems arising within such regional geographical areas.

To date the Federal Civil Defense Administration has encountered difficulty locating physicians qualified and willing to accept these positions. In view of the urgency for hiring these medical directors at the earliest possible date, the Council on National Emergency Medical Service is attempting to assist in locating qualified individuals. I have enclosed for your information, a list of the states included in the nine civil defense regions and the official job description\* for this job which pays \$10,800 per year.

You will be performing a real service if you will publicize this information within your State Medical Society and your circle of acquaintances. If you know of any persons who are or may be interested, please supply me with their names and addresses at your earliest convenience.

Sincerely,

C. JOSEPH STETLER,  
Secretary,  
Council on National Emergency  
Medical Service, A.M.A.

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\* On file at the office of the Indiana State Medical Association.





## President's Page



IN RESPONSE to the numerous protests against the unwarranted and atrocious attack on the medical colleges and the practitioners of medicine made by the woman's editor of "The Hoosier Farmer," Edna Moore Colby, I feel impelled to present some reliable data.

"The Hoosier Farmer" is a publication which is supposed to be the mouthpiece for the Farm Bureau, and when I think of the farm subsidies and the largely tax-free operations of the bureau itself in competition with tax-paying enterprises, I recall the words of our Lord, "Let him among you who is without sin cast the first stone." In other words, "People who live in glass houses should never throw stones."

The article, entitled "The Price of Progress," has all the earmarks of arguments emanating from socialistic agencies whose statements and statistics have not been verified but are predicated on hearsay.

A blanket denial of the accusations might well be in order since it is exceedingly doubtful what small percentage of the statements may be true.

Nearly all institutions of higher education, as well as medical colleges, have had financial difficulties due to the fact that tuition paid by the students does not cover the cost of the teaching, hence to increase the number of medical students would only increase the burden. This fact has been recognized by business men and college presidents.

"The grass is always greener on the other side of the fence," and just as the boy reared on the farm had a desire to become a teacher, an engineer or some other professional citizen, so with the advent of the specialties in medicine the practitioners in the smaller communities decided to become specialists.

The Indiana State Medical Association through Dr. F. S. Crockett of Lafayette was perhaps the first organization to realize that there was an increasing exodus of doctors from the urban or rural districts. Then as now it was not altogether an actual shortage of doctors, due to the change in mode of travel, as much as maldistribution. The Rural Health Committee of the Indiana State Medical Association was organized to encourage young doctors to locate in urban or rural communities, and in 1947 the state association approved a scholarship fund for medical students who needed financial assistance and who would agree to locate in areas where medical services were too limited. The Rural Health Committee of the American Medical Association has now been changed to the Council of Rural Health, with Mr. Aubrey Gates as a full-time roving ambassador to aid in rural medical care.

While it is admitted that the number of urban or rural physicians has decreased 13 percent, yet statistics reveal that the increase both in population and number of doctors graduated have kept an even pace at 15 percent, while there has been an increase of 18 percent in medical students.

The authoress of the "Price of Progress" has failed to take into consideration the fact that some folks have failed to discover how to use their doctor, and instead of taking an ill person to the doctor's office have delayed twenty-four or more hours, only to call the doctor out at midnight or later. A great many times a sick animal would not receive such neglect.

To accuse the medical profession of being a "closed corporation" is to display a complete lack of knowledge of the entire structure of medical education which has been responsible for increasing the span of life more than twenty years in approximately the last fifty years.

Space will not permit a reply to all of the gross inaccuracies contained in the aforementioned article, but for a more fair appraisal of efforts being made to continue to maintain the best system of the practice of medicine in the world today, such as that in the United States, I suggest reading the story in "The New York Times," Sunday, March 2, 1952, entitled "Medical Colleges in Vast Expansion."

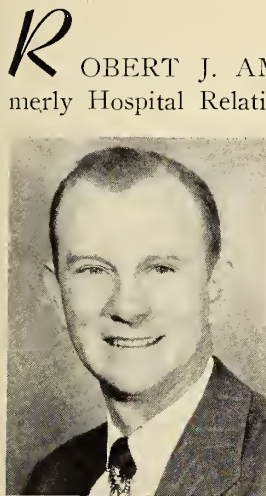
If there were fewer tax exempt businesses and organizations perhaps there would be more funds to distribute to the tax-supported institutions, of which the Indiana Medical Center is one.

*Lawrence Wright*



## ROBERT J. AMICK

### Field Representative



**R**OBERT J. AMICK of Seymour, formerly Hospital Relations Field Consultant for Blue Cross, has been selected as Field Representative for the Indiana State Medical Association. He assumed his new duties on April 1, and will be concerned particularly with field relations in the southern portion of the state.

Mr. Amick was born in Nabb, Indiana, in 1922. He was educated in Scottsburg, graduating from High School there in 1940. He attended Hanover College until 1943 and in 1944 was commissioned in the U. S. Navy.

He served in the Pacific\* until 1946 and from then until 1948 was engaged in personnel work at the Indiana Arsenal. In 1950 Mr. Amick was recalled to active duty and was assigned as assistant to the Operations Officer in Yokosuka, Japan.

He has also been associated with the Indiana Blue Cross-Blue Shield as enrollment secretary, and in 1949 was district manager at the New Albany office. Since release from active duty late in 1951 he has been a Hospital Relations Field Consultant for Blue Cross with headquarters at Seymour.

Mr. Amick is married and has a family of two children. He plans to continue his residence at Seymour, and will travel extensively throughout the southern part of the state.

## Medical Panorama *by the* ASSOCIATE EDITOR

### "YES, WE MAKE HOUSE CALLS"

Under the above heading a reprint of an editorial or possibly a letter to the editor from Detroit appears in *The Pennsylvania Medical Journal* for February, 1952, and we are borrowing about two-thirds of it for transmission to our own readers. It emphasizes the opportunity we all have to be "a public relations committee of one," which should be the most efficient type of committee, after all. Every doctor has this problem, whether he lives in an enormous metropolitan area, like Detroit, or on a hill in one of our distinctly rural counties, so let him read the following:

Speaking on behalf of the doctor of general practice, I can safely say that the vast majority of us are glad to make necessary calls, if we are physically able to do so. But we reserve the right to screen the necessary call from the one that is demanded to suit the patient's convenience or because the patient's judgment is wrong.

We refuse to slide down the greasy pole every time Junior develops sniffles or a blister on his heel. And we intend to protect ourselves against those who want to save themselves some effort and, perhaps, a little money by getting the doctor out on a house call rather than taking a cab to his office. If we try to take care of them all, we find ourselves at the end of the day without the physical strength to go out on that one added necessary call. Then, when we can no longer keep up under the strain, they shout from the housetops that we refused to make a call.

This question has as many angles as a Hollywood divorce. Without attempting to consider them all, let us, each for himself, establish a public relations committee of one to explain the reasons for limiting calls, and to show the disgruntled citizen wherein his grievance may be without foundation at all. There will still be complaints, we know, but if each of us does his part, we can save for the conscientious doctor the credit that is his due.—*Detroit Medical News*, Jan. 21, 1952.

If there are any comments, just write your own letter to the editor.

## POLICIES AND PROCEDURES ADOPTED BY THE DEPARTMENT OF DEFENSE IN IMPLEMENTING PUBLIC LAW 779, 81st CONGRESS

Attention is invited to the following explanation of the policies and procedures of the Department of Defense in implementing Public Law 779 in regard to the manner of calling to active duty physicians and dentists classified as Priority I in accordance with provisions of the law.

The Armed Forces Medical Policy Council has received inquiries from several sources recently concerning this problem. In view of the similar nature of the inquiries, the Council believes that the same questions may be a matter of concern to members of your organization.

MELVIN A. CASBERG, M.D.  
Acting Chairman  
Armed Forces Medical  
Policy Council

AT THE outbreak of the Korean incident, the only source of physicians and dentists available to the military services, other than those already on duty, was the reserve components. At that time the rolls of the active and inactive reserve components of the Army could not supply sufficient medical and dental officers, particularly in the junior grades. Only a very small number of medical and dental ASTP participants had enrolled in the Army Reserve. The Navy, on the other hand, was in a much better position because the majority of the medical and dental participants in the V-12 Program were members of the Naval Reserve. The Air Force was in a position similar to that of the Army, with the exception that it was not an independent department during World War II and, therefore, had not sponsored an educational program.

To insure an adequate number of physicians and dentists to meet military requirements, Public Law 779 (the Docor Draft Act) was enacted. Under its provisions members of reserve components were specifically exempted from registration by the following:

"Section 4i(1) . . . No such person who is a member of a reserve component of the Armed Forces shall, as long as he remains a member thereof, be liable for registration and induction under this subsection, but

nothing in this subsection shall be construed to affect the authority of the President under any other provision of law to call to active duty members and units of the Reserve Components."

The effect of relieving members of reserve components from the obligation to register exempted all participants of the Navy V-12 Program, who were members of the Navy reserve component. This comprised a large group of physicians and dentists who would have been members of the Priority I group if they had not been so exempted. Further, in the Section quoted, specific authorization to call reserve personnel to active duty is reaffirmed and this is interpreted as indicating the intent of Congress that members of reserve components be so utilized at the discretion of the President.

Extensive and earnest study was given to the most equitable and satisfactory method of bringing physicians and dentists to active duty from the increased sources that became available after the enactment of Public Law 779. It was believed, and it still is believed, that the interests of all concerned are best served by the program which was adopted and which has been followed. It consists of assigning a priority classification, paralleling that of Selective Service, to all reserve medical and dental officers which they



would have had under Selective Service had they not been exempt from registration and then calling them to active duty in accordance therewith. Thus, Priority I type reserves which includes Priority I registrants who have indicated a willingness to accept commissions are called up before Priority II's are called. It permits the Navy to utilize its reserves who were obligated to serve and it insures that the Army and the Air Force will have sufficient personnel. It also has the advantage of reducing to a minimum the necessity of actually drafting doctors by affording those who are vulnerable the opportunity of accepting commissions rather than having to face the stigma of being inducted involuntarily.

As the plan has operated, the Navy up to the present time has filled its requirements from its reserve components. The Air Force, with few exceptions, has had a sufficient number of requests for commissions and voluntary applications for extended active duty from Priority I registrants to meet its needs. Except for one month, July 1951, the Armed Forces has been able to fill its requirements for physicians by involuntarily ordering to duty Priority I registrants who have indicated a willingness to accept commissions.

You are well aware of the advantages to the interests of the national welfare in having the local and State Advisory Committees of the Selective Service System advise the military departments on the essentiality of reserves destined for calls to duty. This arrangement has proved its merit and the departments have cooperated with it in a satisfactory manner even though the obligation to do so in the cases of reserve personnel is not prescribed under the provisions of Public Law 779.

It is true that there are some recalcitrant Priority I registrants who refuse to accept commissions and are escaping duty as long as a sufficient number to meet the requirement do volunteer. Their number, however, is relatively small. According to Selective Service statistics for January 31, 1952, of an original 10,785 Priority I living registrant physicians, 1,094 remain immediately available; and of an original 3,928 Priority I registrant dentists, 620 remain immediately available. Since January 31, 1952, the available Priority I dentist pool has been reduced by the induction calls for 335 dentists in April 1952 and 175 dentists in May 1952.

When all Priority I type reserves have been called to active duty, or deferred for acceptable reasons, the Selective Service System will be requested to bring the remaining Priority I registrants into service before any Priority II type reserves are called up. It is anticipated that this will occur within the next six months; hence, the recalcitrant ones are only delaying their service until all the Priority I registrants who have accepted commissions are called up. It is a matter of opinion whether this is to their advantage. If the military emergency should cease to exist before they are inducted, they will have escaped military duty. On the other hand, if the emergency continues, they will be forced to come into service at a later date and will have to serve after their more willing contemporaries are returned to civilian life and become reestablished in their practices.

It has been the desire of the Department of Defense to comply with the intent of Public Law 779. It is believed that as far as practicable this has been done to the best interests of the individuals and of the Armed Forces.

### WARNING!

The Ritter Company, Inc., of Rochester, New York, reports that they are repeatedly asked "Is it safe to use the motor elevated Multi-Purpose Tables, the Motor Chair or the Bone Surgery Engine in hospital operating rooms where cyclopropane or similar anesthetics are in use?" and that the answer is emphatically "NO!" The Multi-Purpose Tables equipped with

Underwriter Laboratory approved Explosion-proof Base and Conductive Rubberized Fabric Upholstery are the only items of Ritter equipment which are safe for such use. The Ritter Company urges that purchasers of this equipment and responsible authorities in institutions where this equipment is in use keep these facts in mind.

## COMMITTEE PAGE

**T**HE Committee on Industrial Health has completed its work on "Medical Direction for the Nurse in Industry." This was compiled by a subcommittee consisting of Louis W. Spolyar, M.D., Allan K. Harcourt, M.D., with E. B. Lamb, M.D., as chairman, and was published in *THE JOURNAL* for February, 1952.

At the present time it is being reprinted in the form of a pamphlet for distribution to all the physicians of the state. It will also be sent to all industrial nurses of the state and to other nurses on request. The pamphlet will be of a convenient size and will have a special cover, and blank pages for insertion of special instructions and authentication by each plant physician.

The preparation of this instructional outline has aroused the interest of industrial physicians from all parts of the country. Many of the leading medical directors for large industries have contributed suggestions and constructive criticism toward its completion.

Your Committee on Industrial Health feels that all the doctors of Indiana should receive the reprint pamphlet, since much of the industrial medical work is done by physicians who are not necessarily specialists in this field.

In this connection our committee is also preparing a leaflet to explain the method of determining the percentage of disability in major industrial accidents. Copies will be mailed to all the doctors in Indiana.

E. S. Jones, M.D., attended the Twelfth Annual Congress on Industrial Health in Pittsburgh in January of this year. An entire day of the program was devoted to reports by chairmen of Industrial Health Committees of different states on the activities within their own states.

A discussion was held on the code of ethics, formulated by this committee, to improve the consideration of cases before the State Industrial Board. Numerous requests have been received for a copy of the code. An excellent suggestion was made that the Chambers of Commerce at various levels would be interested in cooperating with physicians and medical societies in encouraging a better relation between industry and industrial medicine. This endeavor is especially recommended for the smaller industries.

### Committee on Industrial Health

E. S. Jones, Hammond, *Chairman*  
Richard C. Swan, Anderson  
John W. Hilbert, South Bend  
Louis W. Spolyar, Indianapolis  
Emmett B. Lamb, Indianapolis  
Allan Harcourt, Indianapolis



# The Fourth Estate Looks At Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

## DOCTORS' PLAN FOR GRIEVANCE COMMITTEE CONFUSES 'PATIENT,' SO HE HAS PROPOSAL

A week or so ago the Clark County Medical Society, now headed by Dr. Eli Goodman of Charlestown, announced that it had established a patient-physician relationship committee to look into cases involving complaints on medical services and fees.

To sum it up without using too many additional words, this committee will hear complaints from the patient if he feels the pain was too intense in the region around the hip pocket, and do something about it if possible.

Not many persons, perhaps, gave the announcement any more thought than they would the appointment of a custodian of clams by the Mystic Knights of the Sea. If the doctors wanted to set up a sort of grievance committee—well and good. It had been done before in other localities.

Not so, however, with an inquiring gentleman from Clarksville by the name of Al W. Kockentiet. Kockentiet, who lives at 617 N. Marshall, felt he had something to say as a member in good standing of the patient clan, and forthwith penned us a long piece.

The substance of his piece was simple. He merely wondered if maybe some doctors weren't in too big a hurry, and if maybe somebody had the cart and the horse mixed up again.

He put it this way:

"We wish Dr. Goodman a lot of success in his work, but we are confused. As we see it, people will be invited to come to a meeting and bang away their grievances.

"The patients I know usually complain only in extreme cases. It seems to me the doctor who is making the charges, or fees, should be aware of it at the time.

"Consequently, we think Dr. Goodman could do a lot better by setting up a jury of doctors who are fair-minded chaps, and then invite the others in for edification purposes."

—*Louisville Courier Journal*

## FOR WHOM DOES HE SPEAK?

In the Letters column today, a union worker expresses his distaste for the poisonous distortions of truth being made in his name by a radio commentator named Frank Edwards.

Edwards broadcasts from Washington and is introduced as being "sponsored by the eight million men and women who make up the American Federation of Labor." He appears to believe that business, industry and the government are in league to ruin the country, starve the workers, and somehow live in peace and luxury on the result.

Most listeners discount the "language of labor," and understand that extreme accusations are traditional. An "enemy" is somebody who doesn't agree with you and a "fascist beast" is somebody who speaks disrespectfully of Franklin Roosevelt.

Labor unions have the same right as anyone else to criticize any laws, individuals and institutions that they please. But an organization with the power and prestige of the American Federation of Labor, for its own sake as well as the interests of the country, ought not to be responsible for the rank demagoguery and flagrant distortions of truth that it is now sponsoring.—*Chicago Daily News*.

The roar of dissatisfaction is ever louder from the rural families concerning the lack of medical service. "It is not merely scarce doctors that get us down," complained Newton James, a grain farmer off U.S. 41 Tuesday, "it is their indifference, their profiteering rates, and their insolent attitude that wears me thin."

\* \* \*

We heard a lot of griping in Huntingburg over the week end and it seemed to us that town has more and better doctors than most. On one street in front of a doctor's office, however, we counted 56 automobiles. The doctor was supposed to be in his office only from 7 p.m. to 8 p.m.

Every week we hear of doctors making \$1,000 a week. His waiting room is full and he is rated the richest man in the township. I have had 11 clippings, from readers, clipped from the state Farm Bureau magazine which hits the spot on the shortage of physicians.

—*Indianapolis Star*

## News Notes

### Roy H. Behnke, M.D., Gets \$30,000 Teaching Grant

Dr. Roy H. Behnke, Indianapolis, has received a \$30,000 teaching grant from the John and Mary R. Markle Foundation, New York, it was announced yesterday.

Twenty-one young scientists, all medical school faculty members, have been named as the fifth group of Scholars in Medical Science by the Foundation. This is the largest number appointed for any year since the program began in 1948. With total appropriations of over \$2,500,000 for this program, the Foundation is now making grants toward the support of 87 doctors in 49 medical schools.

The purpose of the program is to help relieve the shortage of medical school teachers and investigators by providing academic security and financial assistance for young faculty members early in their careers. All grants are made direct to the medical schools at the rate of \$6,000 annually for five years, and are earmarked for support of a specific scholar and his research.

Doctor Behnke, the first candidate from Indiana to receive the grant, will begin his new duties as instructor in medicine at the Indiana University School of Medicine, July 1.

The fifth annual **Industrial Microbiology Institute** will be held at Purdue University during the week of July 21 to 26. The short course is designed particularly for the scientists from industry or universities who are working with molds and fungi, their identification and control.

In addition to the Purdue staff, which is headed by Dr. C. L. Porter, professor of botany and head of the Institute, several specialists in the field of microbiology will appear on the program. Inquiries relative to the short course should be sent to the Industrial Microbiology Institute, Division of Adult Education, Purdue University, Lafayette, Indiana.



Dr. C. L. Williams, has succeeded Dr. Max A. Bahr as superintendent of Central State Hospital in Indianapolis. Doctor Williams formerly was superintendent of Longcliff State Hospital at Logansport, and was the first director of the Indiana Council for Mental Health. He served as chief of professional services at the Veterans Administration Hospital in Lexington, Kentucky, prior to coming to Central State Hospital on March 16. Doctor Williams graduated from Indiana University School of Medicine in 1926, and practiced in Indianapolis for five years, when he was also an associate professor of psychiatry at Indiana University School of Medicine.

### Tumor Seminar

The Indiana Association of Pathologists, together with the Veteran's Administration Hospital, is sponsoring the 1952 yearly tumor seminar. This year the subject is diseases of the collagen; the moderator, Dr. Paul Klemperer of New York City. The seminar will be held Sunday, May 25, in the new Veteran's Administration Hospital Auditorium. There will be slide sets available in advance of the seminar. A limited number of sets and protocols will be available for pathologists who are not members of the Indiana State Pathologists Association. These sets will be distributed to those who apply, in the order of their applications, as long as they last. A nominal fee of \$10.00 will be charged and this should be sent together with the request for the set to Dr. J. L. Arbogast, Secretary of the Indiana Association of Pathologists, Indiana University Medical Center, Indianapolis.



**SEMINAR IN ANESTHESIOLOGY****May 21, 1952****at****Indiana University School of Medicine****Sponsored by****Indiana University School of Medicine****and****The Indiana State Society of Anesthesiologists****PROGRAM**

8:00- 8:30 Registration, Office, Department of Anesthesiology, Laboratory-Science Building, Room No. 127

8:30-10:45 Clinics, Operating Rooms in Clinical Building and Riley Hospital

**MORNING MEETING****Hurty Hall—Laboratory-Science Building**

Arthur W. Hull, M.D.—Presiding  
Elkhart, Indiana

10:50-11:00 Remarks of Welcome—  
John D. VanNuys, M.D., Dean  
Indiana University School of Medicine

11:00-11:30 "Means of Artificial Respiration by Intermittent and Positive Pressure Methods"  
Mr. John B. Dunne  
Mine Safety Appliances Company  
Pittsburgh, Pennsylvania

11:30-12:00 "Clinical Trial Drugs Being Investigated at the Indiana University Hospitals, Department of Anesthesiology"  
John P. Graf, M.D.  
Indiana University School of Medicine

12:15- 1:30 Dinner—Dining Room—Riley Hospital

**AFTERNOON MEETING****Veterans Administration Hospital, 1481 W. 10th St., Indianapolis**

Arthur W. Hull, M.D.—Presiding  
Elkhart, Indiana

1:30- 2:15 "Blood Transfusion Reactions in Patients Undergoing Surgery"  
Thomas H. Seldon, M.D.  
Mayo Clinic  
Rochester, Minnesota

2:30- 3:00 "Conduction Anesthesia for the Poor Risk Patient"  
Roger Bryce-Smith, M.D.  
Western Reserve University Hospitals  
Cleveland, Ohio

3:15- 3:45 "Cyclopropane Anesthesia—1951"  
Milton Davis, Jr., M.D.  
University of Wisconsin Hospitals  
Madison, Wisconsin

4:00- 4:30 "Anesthetic Management of the Cardiac Patient"  
Howard A. Bennett, M.D.  
University of Oklahoma Hospitals  
Oklahoma City, Oklahoma

**"Standard Values In Blood"**

The United States Air Force has published a technical report containing the most complete and authentic information available on blood and its characteristics ever assembled.

The report, "Standard Values in Blood," promises to fill a long-felt need in the medical profession. Information for the report was contributed by more than 600 leading medical authorities throughout the world.

Edited by Dr. Errett C. Albritton, of the George Washington University Medical School, this Air Research and Development Command project was monitored for the Air Force by Dr. J. W. Heim of the Aero Medical Laboratory, Wright Air Development Center at Wright-Patterson Air Force Base. The report was prepared by the National Research Council under sponsorship of the Aero Medical Laboratory.

Data included in the more than 100 tables in the report describe practically every known property of blood. Each of the thousands of individual figures was verified at least six times, and some of them were rechecked as high as 20 times by experts in their various fields. The report includes not only numerical data on the physical, chemical and biological properties of blood, but also presents the latest knowledge concerning blood coagulation, blood groups, and the effective blood levels of various drugs and therapeutic agents.

Among the interesting facts revealed in this comprehensive study is that blood contains more than 300 chemical compounds ranging from complex hormones, enzymes and vitamins, to simple metallic elements such as copper, zinc, manganese and iron.

Although primarily compiled to furnish information on human blood, the report also contains similar material for many types of domestic and wild animals.

The Air Research and Development Command report was written to furnish a ready reference manual for use by Air Force medical officers, and also is authorized for distribution to other government agencies. The public will be able to obtain copies from the Office of Technical Services, Department of Commerce, Washington, D. C.

**Dr. Leonard A. Scheele** was sworn in for his second term as Surgeon General of the Public Health Service on April 3. Confirmation of the reappointment was made by the Senate on March 11.

Doctor Scheele is the seventh Surgeon General to be appointed since the position was created by Congress in 1870. He was 40 years old at the time of his first appointment in 1948.

A native of Fort Wayne, Indiana, Dr. Scheele is a graduate of the University of Michigan, and of Wayne University School of Medicine in 1933.

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**Dr. Walter C. Van Nuys**, who served for forty-five years as superintendent of the Indiana Village for Epileptics at New Castle, resigned March 31.

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**Dr. Lester D. Bibler**, of Indianapolis, was named vice-president of the American Academy of General Practice at its annual meeting in Atlantic City in March. **Dr. Norman R. Booher**, of Indianapolis, is vice-speaker of the Academy's Congress.

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#### American College of Chest Physicians

The Eighteenth Annual Meeting of the American College of Chest Physicians will be held at the Congress Hotel, Chicago, June 5 through 8, 1952. A scientific program covering all recent developments in the treatment of heart and lung disease is being arranged.

The Board of Examiners of the American College of Chest Physicians announces that the next oral and written examinations for Fellowship will be held in Chicago on June 5, 1952. Candidates for Fellowship in the College who wish to take the examinations should contact the Executive Secretary, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

Dr. Jerome V. Pace of New Albany serves as Governor of the College for Indiana. Officers of the Indiana Chapter are Dr. Thomas R. Owens, Muncie, President; Dr. John N. Ewbank, Richmond, Vice-President; and Dr. Hubert B. Pirkle, Rockville, Secretary. Dr. James H. Stygall, Indianapolis, is Chairman of the Board of Regents of the American College of Chest Physicians.

**Dr. Arthur L. Beyler** has been appointed to the staff of the Biology Division of the Sterling-Winthrop Research Institute. He received his Ph.D. degree from the University of California and his M.S. and A.B. degrees at DePauw University, Indiana. He has engaged in research and teaching at DePauw University and at the University of California at Los Angeles. Dr. Beyler is a member of Sigma Xi and the American Association for the Advancement of Science. A native of Marion, Indiana, he now resides in Albany with his wife and three-year-old daughter.

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The University of Pittsburgh School of Medicine announces a **Postgraduate Symposium on the Basic Sciences Related to Anesthesiology**. The course will be held June 2 to 6, 9 a.m. to 6 p.m. Registration fee is \$25.00; advance registration required.

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#### General Practice Postgraduate Training

The General Practice Group of the University of Tennessee has established a postgraduate clinical training program for general practitioners. This has been approved by the American Academy of General Practice for its members.

The program is designed for the general practitioner on an individual basis, according to his individual needs. One week to one month of training is offered.

Each doctor will spend morning hours in his choice of any one of the University specialty fields. This will be active work at the resident level. The afternoons will be spent in the General Practice Clinic where the medical students get active general practice experience. Evenings are utilized in the emergency room of the John Gaston Hospital which is supervised by members of the General Practice Staff.

General practitioners who would like to participate or who desire further information, may write to the General Practice Office, University of Tennessee, Memphis, Tennessee. There is no fee charged for this training.



**A.M.A. WASHINGTON OFFICE NEWS**

**Federal, State Medical Stockpiles May Exceed \$80 Million by Mid-Year.**—Latest Civil Defense Administration figures indicate total federal and state stockpiles of medical supplies on hand or on order by July 1 may amount to \$80.5 million. Of this, CDA has committed nearly all of the \$50 million voted by Congress for exclusively *federal regional stockpiles*. In addition, CDA already has given states \$10.5 million which they in turn have matched on a 50-50 basis for *local supplies*. CDA has on hand about \$9.5 million from the original matching fund appropriation which Congress has said may be used for the *federal* stockpile, provided it's committed by June 30.

CDA explains it has the \$9.5 million left over because (a) five states containing critical target areas are not yet participating in the federal-state program, (b) market prices of some supplies have dropped, effecting savings, and (c) additional savings were achieved through simplification of specifications of some items. The states that did not join in the program by the March 15 deadline are Alabama, Georgia, Texas, Louisiana and Illinois.

Civil Defense Administrator Millard Caldwell, meanwhile, had informed Chairman Brien McMahon of Joint Committee on Atomic Energy that medical stockpiling is "unsatisfactory both in volume and quantities of supplies available." Caldwell estimates funds voted by Congress so far would provide enough supplies for only one week of emergency care for 2 million atomic bomb casualties.

For its fiscal 1953 program, CDA is asking Congress for \$193 million for *federal* medical stockpiling. No matching funds for *local* stockpiling are requested for next year.

**Military.**—Army follow-up examinations of 1,000 soldiers back from Korea are underway to test effectiveness of new antimalarial drug, primaquine. The men, exposed to malaria in Korea but with no history of the disease, are receiving a 15-milligram dose daily for 14 days and will remain under observation until October 1.

**VA INCREASES COLLECTIONS ON NON-SERVICE-CONNECTED CASES**

Although still having trouble making collections, Veterans Administration reports it obtained \$1,213,251 from outside sources for treatment of hospitalized non-service-connected cases in the last six months of 1951. This is almost as much as was collected on these accounts in the previous 12 months.

Most money came from *workmen's compensation boards*, which VA described as the "most cooperative" of the insurers. The agency also made efforts to collect from pre-paid medical and hospital care programs and insurance companies, but *these generally refused payment, arguing that VA is not entitled to collect on the policies*. The increase in total collections was attributed largely to the fact that more veterans are being employed in industries under jurisdiction of workmen's compensation boards.

According to a VA legal official, the administration is handicapped in collections by a number of factors:

1. VA bases its claim on an administrative interpretation, not a specific law, and does not want to sue insurers until it has a better legal position.
2. "Exclusion clauses" being inserted in more and more policies prohibit payment to tax-supported institutions, such as federal and state hospitals.
3. Insurers argue that their policies are non-assignable, and therefore that when a veteran assigns his policy to VA, the action is not binding. The claim is also advanced that because VA cannot legally collect from the individual, it is not entitled to collect from the insuring agency.

VA makes no attempt to collect on policies carried by service-connected cases. On non-service-connected cases, it maintains that the veteran signing the "pauper's oath" makes himself eligible for free hospitalization only for the amount in excess of his hospitalization insurance benefits.

# **CALL ON SELECTIVE SERVICE FOR PHYSICIANS DEFERRED TO MAY**

Defense Department again has deferred its call on Selective Service for physicians, this time to May. The call for 485 physicians from Priority I originally was issued for last August and September. However, volunteers for the reserves from Priority I have made it possible for Defense Department to defer the call from month to month. There is no assurance that the call can be deferred again, the Department emphasized, stating that "If, in the future the number of registrants who accept reserve commissions should fail to meet requirements, it will become necessary to make up shortages through induction."

## **NEW EFFORT UNDER WAY TO GET PRIORITY I PHYSICIANS TO JOIN RESERVES**

A new effort is being made to induce about 1,000 physicians rated in Priority I of the doctor-draft to sign up for service in the military reserves. Men involved were educated at government expense during World War II or deferred from service to continue their medical educations, but so far have not applied for reserve commissions.

*National Advisory Committee to Selective Service* (Dr. Howard A. Rusk, Chairman) declares: "Various state committees, as well as the National Committee, have been deeply concerned over these individuals who did not at the time of special registration apply for a commission and have not subsequently done so while other more willing individuals have accepted commissions and many of them are now serving in the armed forces."

*Selective Service Director* Louis B. Hershey says these "inequities" can only be prevented by calling up physicians through Selective Service (not the reserves).

The acting chairman of *Defense Department's Medical Policy Council*, Dr. Melvin A. Casberg, warns: "When all Priority I type reserves have been called to active duty . . . the Selective Service System will be requested to bring the remaining Priority I registrants into service before any Priority II type reserves are called. It is anticipated this will occur within the next six months. Hence, the recalcitrant ones are

only delaying their service until all Priority I registrants who have accepted commissions are called up."

Meanwhile, Defense Department has announced that 290 medical reserve officers will be called to active duty in July. Included will be 135 physicians. All are Priority I type reserves and will serve for two years.

## **Budget Bureau Won't Recommend Passage of EMIC Bills, Rejects Hospitalization.—**

Bureau of the Budget has informed Chairman Lehman of Senate Health Subcommittee that it cannot recommend passage of *Emergency Maternity and Infant Care bills now under study and that it disapproves the plan for free hospitalization of servicemen's dependents*. The Bureau does suggest, however, that Congress give "thorough consideration" to the underlying problems of medical care to dependents of all military personnel. Budget Bureau Director S. J. Lawton wrote the subcommittee, which held hearings on S.1245 (by Senator Humphrey) and S.2337 (by Senator Lehman), as follows:

"In reviewing measures which deal with the particular need for which these bills are designed, we feel that the committee will wish to consider the relative increases . . . in military pay and allowance scales since the EMIC program was enacted in World War II, and the military pay bills now pending." (Final action is due shortly on the military pay raise bills to which Mr. Lawton referred. The House has passed its bill, and the Senate expects to act on its version in a few days.)

Mr. Lawton cited Defense Department estimates that 240,000 births to wives of enlisted men would occur this year, with military installations capable of handling 70,000 of these. Notwithstanding, the Budget chief stated: ". . . we cannot recommend enactment of Title I of S.2337 (EMIC) on the basis of data made available to us . . . These comments also are applicable to S.1245. With respect to Title II of S.2337 (hospitalization of dependents), we recommend against favorable action by the committee."



## *Indiana University News Notes*

An expanded class of 150 students has been chosen for the fifth successive year for admission to the Indiana University School of Medicine.

The winnowing of hundreds of applicants to the 150 that can be accommodated by the school's present physical plant and teaching staff was announced by Dean John D. Van Nuys. Selection had been made by a faculty-practicing physician committee after weeks of study of premedical grades, medical aptitude and other tests, and personal interviews.

Existing facilities of the school were designed for 128 entering students each year. Added legislative appropriations for staff and staggered class schedules have enabled the school since 1948 to raise the number to 150 in an effort to alleviate the state's shortage of physicians. Under legislative direction, study is being made as to future needs and expansion.

Students chosen will begin their medical training here next September. They include 144 residents of Indiana and the normal six out-of-state students, the latter chosen as reciprocity with other states admitting Hoosier students to their medical schools. The students selected are:

Francis H. Balcom, Bernard L. Berman, William C. Bogan, Paul E. Bryan, Leonard J. Burman, Peter H. Cahn, William H. Call, Paul K. Cullen, Jr., Frank H. Dailey, Ramon S. Dunkin, Richard E. Ferguson, John B. Fitzgerald, Joseph C. Fralich, Richard A. Gooding, John T. Haynes, Isadore E. Hurwitz, Laveta Audrey Johnson, Leon G. Kaseff, Maxwell S. MacCollum, Marilyn Markovitch, Henry E. Martinez, John C. Mason, Dean H. Morrow, Donald K. Nelson, Aaron Rabb, Robert D. Robinson, John J. Roget, George E. Stahl, Neil R. Strickland, and Neil L. Wilson, Indianapolis;

Walter Able, Jr., Seymour; John E. Allen, Jr., Otisco; Louis Alvarez, Edward R. Bakos, Chester J. Kmak and Robert Lozano, East Chicago; Lucian A. Arata, Mishawaka; Myrle E. Artis, Jerome J. Ballantine, Jack H. Hall and Gerald D. Timmons, Kokomo; William C. Ashman, Wallace H. M. Chun and Jack B. Crosby, Greencastle; Reginald R. Bartin, James A. Friedman, Charlotte Lashley, John W. Luttrull, Rodney F. Porro and Paul A. Schneider, Evansville; Thomas A. Beck and Pierre J. Fisher, Jr., Marion; Jack S. Berebitsky,

Donald G. Fisher, Lyall L. Frank, Jr., and Donald G. White, South Bend; Leon I. Block, Connersville; William D. Boaz, New Albany; Clarence W. Boone, William P. Chalos, George R. Daicoff, Ronald H. Doneff, James R. Doty, Jr., John J. Gillinatti, William T. McLaughlin, Violet Matovich, Eddie T. Pappas, Gary; James H. Booze, Quentin L. Erd, John D. Lacy, Jr., William H. Lorack, and Robert P. Schloss, Bloomington;

Don W. Boyer, Kirklin; George J. Brewer and Stephen D. Soohey, Crown Point; Robert J. Burkle, Daniel L. McKinney and Robert W. Masters, Lafayette; David R. Cain, Huntington, W. Va.; John O. Carter, John B. Clauser, Robert L. Costin, Robert S. Hall, and Kenneth W. Koss, Muncie; James K. Chamness and Diana Eddy, Michigan City; Jack P. Clark, Syracuse; Pete R. C. Classen, Ervin W. Heiser, Jr., and James D. Reid, Goshen; Robert C. Coddington and A. Wendell Musser, LaPorte; Wilson J. Cooper and Robert M. Williams, Jeffersonville; Rex D. Couch, Fairmount; James C. Cupp, North Vernon; Fred W. Dahling, New Haven; Morton W. Dann, New Castle; Russel M. Day, Huntingburg; Robert E. Deadman, Poseyville; James N. Easter, Sterling Theobald and Clinton S. Wainscott, Jr., Peru; James L. Feeney, Pierre, S. D.; Richard L. Fields, Andrews; Thomas M. Foreman, Munster;

Lawrence N. Frazin, Ft. Harrison; Carl J. Freund, South Whitley; William B. Gill, Jr., Hammond; Herman H. Glassman, Hartford, Conn.; James C. Graham, Andrew E. Russo and Eugene N. Smoley, Fort Wayne; Erwin J. Gutowitz, Decatur; John B. Guttman, Walkerton; William L. Haskins, Ironton, O.; Gordon J. C. Hershey, Churubusco; Francis M. Highly, Jr., and Benjamin P. Kietzman, Chesterton; John H. Hines, Auburn; Paul M. Inlow and Robert P. Inlow, Shelbyville; Robert L. Irick, Frankfort; Kenneth G. Lansford, Redkey; Richard M. LaSalle, Wabash; Harry O. Leader, West Lafayette; Paul S. Lewis, Terre Haute; David H. Lobdell, Dearborn, Mich.; Paul C. McKinney, Otterbein; George D. Mancisci, Elkhart; William G. Moore, Kingman; Elmer N. Nussbaum, Monroe; Seymore Oberlander, Whiting; Robert K. Osborne, Bloomington; Harley P. Palmer, Jr., West Newton; Ronald L. Peterson, Logansport;

Richard N. Philbert, Bill R. Ryan and Theodore C. Smith, Anderson; Larry F. Smith, Richmond; Max E. Sneary, Avilla; Thomas R. Sprenger, Ashland, Ky.; William E. Stansbury, Tell City; Collins R. Wallace, Crawfordsville; James A. Way, Zionsville; Carol Lee Wickham, Grayville, Ill.; John F. Williams, Jr., Franklin; Ned A. Wilson, Bridgeport; John S. Wilson, Columbia City, and Clarence R. Woodbury, Portland.

Specialists in the field of radiology were guests on the Medical Center campus recently to attend a series of conferences conducted by Dr. Joseph L. Morton of the Ohio State University School of Medicine and radiologist for the university's hospital. He is well known for his work with radioactive cobalt as a substitute for radium in the treatment of cancer.

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Dr. R. L. Thompson, chairman of the Department of Microbiology, attended the conference on chemoprophylaxis and chemotherapy of virus infections held at the University of Michigan, under the sponsorship of the National Foundation for Infantile Paralysis.

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Dr. Fred Wilson of the Department of Ophthalmology presented a paper, "Ophthalmoscopic Evaluation of the Hypertensive Patient" before a conference at the University of Kansas Medical Center in Kansas City, last month.

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The meeting of the American Association of Psychiatric Clinics for Children and the American Orthopsychiatric Association, held in Atlantic City, was attended by Dr. Samuel Warson, director of the Child Guidance Clinic.

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Twenty-two specialists from 13 states, in addition to the staff of the Department of Otorhinolaryngology, attended the postgraduate program presented by the department at the Medical Center recently. Dr. Maurice Cattel of Chicago, as visiting lecturer, presented the program.

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Dr. Charles A. Doan, one of the authorities in research on blood and also dean of the Ohio State University College of Medicine, presented the third annual Burton Dorr Myers lecture February 29, under the auspices of the Nu Sigma Nu medical fraternity. Dr. Doan discussed "Management of Hemolytic Anemias." A dinner, given by the fraternity, preceded the lecture.

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Dr. Frank Miller and Mrs. Maressa Hecht Orzack, Ph.D., have been appointed Research Fellows in Ophthalmology. Dr. Miller, formerly in general practice in Morristown, is studying the incidence of tubular vision. Dr. Orzack, daughter of Selig Hecht, noted for his visual research, is working on the Liebman effect in binocular perception.

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Dr. William C. Clark, at present a member of the University of Illinois staff, has been named assistant professor of Biochemistry and Pharmacology at the I. U. School of Medicine. Dr. Clark will be on a part-time basis until the close of the semester at Illinois. He holds degrees from the St. Louis College of Pharmacy, and an M.S. degree from the University of Illinois and is completing work there for a Ph.D. degree.

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Dr. L. T. Meiks, Dr. Paul Lurie and Dr. Byron Rust, of the Medical School staff, and Dr. Roland Miller of Lafayette presented the March Telephone Seminar in the auditorium of the School of Medicine. "Care of the Infant During the First Year" was the topic discussed.

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As a guest of the Department of Neurology and Psychiatry, Dr. I. Arthur Mirsky, Chairman and Professor of Clinical Science at the University of Pittsburgh, addressed the medical students on "Psychiatry and the Medical Sciences" on March 12. At eight o'clock that evening he spoke at a meeting of the Indiana Neuropsychiatric Association in the Clinical Building auditorium.

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Dr. Carl P. Huber presented a paper at the National Cancer Conference held in Cincinnati, Ohio, March 3-5. Other members of the Medical Center staff attending the meeting were: Dr. E. A. Lawrence, Dr. Glenn Irwin, Dr. Robert Garrett, and Dr. Robert Rohn.

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Dr. J. S. Battersby, Dr. William Coxe and Dr. Harold King were in Toronto, Canada, March 5-9 attending the Central Surgical Association meeting. Dr. King presented a paper at the meeting.



The Medical Center librarians, Miss Mary Jane Laatz, Miss Josephine Williams and Mrs. Letitia Carter, have been invited by the extension division of the State Library to assist in establishing a patient library at Central State Hospital. This work is done on a voluntary basis. Miss Laatz, acting librarian of the Medical School, will also help in the establishment of a medical and patient library at the LaRue D. Carter hospital. Librarians from the Medical Center, Methodist hospital and St. Vincent's hospital are all cooperating in the work.

Mrs. Winifred C. Kahmann, in the capacity as president of the National Association of Occupational Therapy, attended a mid-year board and educational committee meeting of the association held in Chicago March 15-16.

Dr. Edwin Kime was in New Orleans March 14-20 attending the educational conference of the Academy of Prosthetics, Clinical and Functional Anatomy Postgraduate Education.

## Deaths

**Stanton E. Gordin, M.D.**, of Connersville, died on March 4, at the age of eighty-one. He had been ill for four months. After graduating from the Chicago Homeopathic Medical College, in 1896, he practiced in Chicago for a short time, before moving to Connersville, where he had practiced ever since. Doctor Gordin was an Honorary member of the Fayette-Franklin County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

**Raymond A. Naugle, M.D.**, of Wabash, died on March 21 after a long illness. He was fifty-six years of age. A graduate of Indiana University School of Medicine in 1920, he had practiced in Wabash since 1921. Doctor Naugle was a member of the Wabash County Medical Society, the Indiana State Medical Association, and the American Medical Association.

**James E. McMeel, M.D.**, of South Bend, died suddenly on March 27, at the age of sixty-three. A 1913 graduate of Rush Medical College in Chicago, he began his practice in South Bend in 1917, where he had practiced ever since. Doctor McMeel was a veteran of World War I, and was a member of the St. Joseph County Medical Society, the Indiana State Medical Association, and the American Medical Association.

**Otis B. Nesbit, M.D.**, of Gary, died on March 18, at the age of eighty-one. He had practiced in Valparaiso from 1903 to 1913, before going to Gary, where he had practiced since 1913. Doctor Nesbit graduated from the Bennett Medical College, of Chicago, in 1902. He was an Honorary member of the Lake County Medical Society and the Indiana State Medical Association, and was a member of the American Medical Association.

**Edward R. Wallace, M.D.**, of Aurora, died on March 7, after a long illness. He was seventy-five years of age. A graduate of Pulte Medical College, in Cincinnati, in 1906, he had practiced in Aurora since 1907 until his retirement three years ago. Doctor Wallace was a former member of the Dearborn-Ohio County Medical Society, the Indiana State Medical Association, and the American Medical Association.

**Cecil F. Jordan**, of Denver, Indiana, died on March 16, after a brief illness, at the age of seventy-three. After graduating from the University of Michigan Homeopathic Medical School in Ann Arbor, in 1904, he practiced in Wabash and in Peru until moving to Denver approximately ten years ago. Doctor Jordan was a former member of the Miami County Medical Society, the Indiana State Medical Association, and the American Medical Association.

## Society Reports

### INDIANA STATE MEDICAL ASSOCIATION

#### EXECUTIVE COMMITTEE

March 16, 1952

Roll call showed the following present: W. L. Portteus, M.D.; J. William Wright, M.D.; Paul D. Crimm, M.D.; Wemple Dodds, M.D.; Roy V. Myers, M.D.

Frank B. Ramsey, M.D., editor of *THE JOURNAL*; Albert Stump, attorney; James A. Waggener, executive secretary.

Guest: Cleon A. Nafe, M.D.

#### Membership Matters

##### (1) Membership report:

Number of members, March 15, 1952	3,185
Number of members, March 15, 1951	3,156
Gain over last year	29
Number who have paid AMA dues:	
1950	2,907
1951	2,938
1952	2,701

(2) Nomination of Dr. L. A. Ensminger for Associate Fellowship in the AMA was authorized on motion of Drs. Wright and Crimm.

(3) Upon motion of Drs. Wright and Dodds, the proposed new form for collecting dues was approved.

#### Indiana Student AMA

Dr. Cleon A. Nafe, the association's adviser to the Indiana Student AMA, appeared before the committee for a discussion of matters relating to the organization of the Indiana chapter.

Upon motion of Drs. Wright and Myers, the Executive Committee recommended and instructed the state office to extend an invitation to three members of the Indiana chapter to attend House of Delegates' meetings of the Indiana State Medical Association as guest delegates, with all privileges of the House granted them except the power of voting.

Upon motion of Drs. Wright and Crimm, the Executive Committee is to recommend to the Council that the Council recommend to the House of Delegates that representatives of the Indiana chapter of the Student AMA be invited to sit in as observers on reference committee hearings and other committee meetings of the association; also, that some sort of liaison be established between the association and the Indiana chapter of Student AMA and other organizations whereby arrangements could be cleared through the headquarters

office for establishing externships in hospitals and preceptorships during the junior and senior years, this to be done in consultation and with the approval of the Medical School.

#### Headquarters Office

The matter of field secretary was discussed and upon motion of Drs. Crimm and Myers, Robert J. Amick of Scottsburg was employed as field secretary for southern Indiana. Mr. Amick is to begin his employment April 1, 1952.

Statements of receipts and expenditures for February for the association and *THE JOURNAL* were approved.

#### 1952 Annual Session, Indianapolis, October 28, 29 and 30, 1952:

Upon motion of Drs. Wright and Crimm, the committee approved the proposed scientific and entertainment program and the specifications governing the rules for exhibits at the annual session.

#### Legislative Matters

*Local*—Dr. Nafe again discussed the matter of the Internal Revenue ruling on fee rebates and the secretary explained the attitude of the American Medical Association in being opposed to their procuring a ruling from the Washington Bureau inasmuch as the Judicial Council of the A.M.A. held this unethical and the A.M.A. did not care to place itself in the position of justifying the ethics of fee rebates.

It was also explained that the Legal Department of the A.M.A. felt that the Internal Revenue Department had based its ruling upon the Circuit Court of Appeals action in the Lilly case, and inasmuch as the Supreme Court had reversed the lower court's decision, the Revenue Department did not have a basis for its ruling. The legal counsel of the association discussed and read the report of the Supreme Court and it was his opinion that the Supreme Court ruling did not affect fee rebates and the practice of medicine per se.

Upon request of the committee, the association's legal counsel is to prepare a statement of opinion for insertion in *THE JOURNAL* regarding this matter.

#### Organization Matters

(1) Upon motion of Drs. Wright and Crimm, the committee recommended the letter from the Indianapolis Medical Society, addressed to PTA presidents, regarding federal aid to education to the Council with the suggestion that the associa-



**SEARLE**

# Aminophyllin\*

## increases cardiac output

*"improves exercise tolerance by 42 per cent"*<sup>1</sup>

**oral  
parenteral  
rectal dosage forms**

**Indicated in:**

Dyspnea of Congestive Heart Failure

Bronchial Asthma

Status Asthmaticus

Pulmonary Edema

Control of Cheyne-Stokes Respiration

**Also of value as:** Peripheral Vasodilator<sup>2</sup>

1. Kissin, M.; Stein, J. J., and Adelman, R. J.: *Angiology* 2:217 (June) 1951.

2. Rickles, J. A. J. *Florida M.A.* 38:263 (Oct.) 1951.

\*Contains at least 80% of anhydrous theophylline.

**SEARLE****RESEARCH IN THE SERVICE OF MEDICINE**

tion also oppose federal aid to education and prepare a letter similar to that written by the Indianapolis Medical Society.

(2) Request of the Indiana Mental Health Council for the association to approve their request to the Medical Board for granting temporary licenses to psychiatrists who have graduated from recognized foreign schools to practice in Indiana's mental institutions was tabled pending receipt of information from the Neuro-Psychiatric Association and others who would be involved if such a ruling were made by the Medical Board.

(3) Upon motion of Drs. Wright and Dodds the committee approved the spending of \$75.00 for a half-page ad in the Press Club's Gridiron dinner program.

(4) Upon motion of Drs. Wright and Dodds, the committee authorized the sending gratis of a copy of ONE HUNDRED YEARS OF INDIANA MEDICINE to the Library of Congress.

(5) The Executive Committee is to recommend that the Council establish dates which the headquarters office shall use for the apportionment of delegates for the meetings of the House of Delegates, and also that all counties select their delegates in December of each year, these delegates to serve for a full year.

#### The Journal

##### (1) Report on advertising:

Total, March, 1951-----	\$2,436.01
Total, March, 1952-----	\$2,094.11
Loss over last year-----	\$ 341.90
Total, first quarter, 1951-----	\$6,729.82
Total, first quarter, 1952-----	\$6,228.14
Loss -----	\$ 501.68

(2) The editor of THE JOURNAL stated there had been some inquiry as to the establishment of a special subscription rate to THE JOURNAL for medical students. The matter is to be investigated and reported on at the next meeting of the committee.

There being no further business, the committee adjourned to meet again at 2:00 p. m., Saturday, April 26, 1952, at the Columbia Club.

#### COMMITTEE ON PUBLICITY

March 7, 1952

Present: D. S. Megenhardt, M.D., chairman; James O. Ritchey, M.D.; and Jas. A. Waggener, executive secretary.

The following "Hints on Health" columns were approved:

- Week of April 28, 1952—"Carbon Monoxide"
- Week of May 5, 1952—"Hiccups"
- Week of May 12, 1952—"Your Feet"
- Week of May 19, 1952—"Birthmarks"

A new series of Radio Transcriptions entitled "Panorama of Research" was selected for use following expiration of the present series.

#### COUNTY MEDICAL SOCIETY OFFICERS

##### ADAMS COUNTY MEDICAL SOCIETY

President, Arthur H. Girod, Decatur  
Vice-President, Harold F. Zwick, Decatur  
Secretary-Treasurer, Norman E. Beaver, Berne

##### ORANGE COUNTY MEDICAL SOCIETY

President, Philip Hodgins, Orleans  
Vice-President, W. E. Schoolfield, Orleans  
Secretary-Treasurer, Keith Hammond, Paoli

#### LOCAL SOCIETY REPORTS

Allen County (Fort Wayne) Medical Society members met at the Chamber of Commerce in Fort Wayne on March 4. The guest speakers were Dr. Russell DeJong and Dr. B. K. Bagchi, of Ann Arbor, Michigan, who spoke on "Convulsive Disorders," and "Electroencephalography." Fifty members were present.

Another meeting was held on April 1, when members of the society were guests of the Lincoln National Life Insurance Company. A panel discussion on "Relationship of Medicine to Insurance," was held, followed by a paper on "Evaluation of Abdominal Complaints," by Dr. H. Marvin Pollard, from the University of Michigan Medical School.

Boone County Medical Society members met at the Witham Memorial Hospital in Lebanon on April 1, when the members participated in the telephone seminar.

Hamilton County Medical Society members met at the hospital in Noblesville on March 11. The speaker was Miss Frances Neal, Hamilton County prosecuting attorney, who spoke on juvenile delinquency.

Huntington County Medical Society members met in Huntington on January 8, when Dr. Cecil McEachern, of Fort Wayne, spoke on "Surgery of the Stomach and Duodenum." Eighteen members were present.

On February 5 they met at the Hotel LaFontaine in Huntington, when the seventeen members present viewed a film on obstetrical problems.

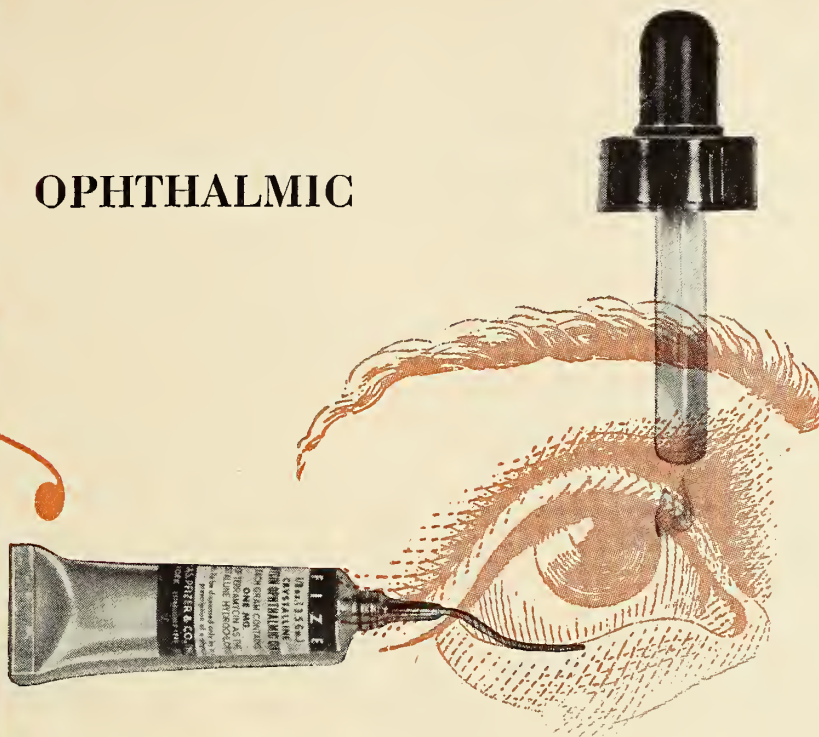
Another meeting was held there on March 4, when Dr. Richard Stauffer of Fort Wayne spoke on "Fractures of the Lower Extremities." Fourteen members were present.

LaPorte County Medical Society members met in Long Beach on March 20. Thirty-two members were present to hear Dr. A. H. Verbrugghen, of Chicago, speak on "Head Injuries From the G.P.'s Viewpoint." A motion was passed to assess members of three year's duration \$100 each, and those of less than three years' duration \$50, for the Medical Education Foundation.



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OPHTHALMIC OINTMENT, 5 mg. per Gm. ointment;  
tubes of  $\frac{1}{8}$  oz.

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OPHTHALMIC SOLUTION, 5 cc. vials containing  
25 mg. for preparation of topical solutions  
isotonic with lacrimal fluid and buffered to pH 8.2.

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Elixir, Oral Drops, and Intravenous.

ANTIBIOTIC DIVISION



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Lawrence County Medical Society members met at the Dunn Memorial Hospital in Bedford on March 12. Ten members were present to hear a wire recording on "Care of Infant, First Year."

Madison County Medical Society members met at the Anderson Country Club on March 17, when forty members were present. Dr. C. Basil Fausset, of Indianapolis, discussed new developments in neurosurgery, and Dr. Earl Mericle, of Indianapolis, discussed recent developments in neuropsychiatry.

Montgomery County Medical Society members met at Culver Hospital in Crawfordsville on March 20. Mr. G. L. Gineris and Mr. Converse, from Blue Shield, spoke on "The Power of Your Vote." Twenty-eight members were present.

Orange County Medical Society members met at West Baden Springs Hotel on April 11. This was a business meeting, and six members were present.

Parke-Vermillion County Medical Society members met at the Vermillion County Hospital on March 19. Dr. William Kriebel, of Terre Haute, spoke on "Diseases of the Heart." Ten members were present.

Putnam County Medical Society members met at the DePauw Memorial Union Building, in Greencastle, on March 14. Dr. R. D. Solomon, of Terre Haute, spoke on "Carbohydrate Metabolism." Sixteen members were present.

St. Joseph County Medical Society members met at the Northern Indiana Children's Hospital in South Bend on March 11, when a symposium on geriatrics was presented.

Vanderburgh County Medical Society members met at the Hotel McCurdy in Evansville on April 8, when more than seventy-five members heard Dr. Robert A. Garrett, assistant professor of Urology of the Indiana University School of Medicine, speak on "Problems of Pediatric Urology."

The Society purchased from its treasury enough of the new A.M.A. office plaques to supply the office of each member. The society received very favorable newspaper publicity on this project.

The Vanderburgh County Medical Society went on the air with its new radio program, "This Is Your Doctor's Office," on April 11, at seven o'clock over station WEOA in Evansville. The program, developed entirely by the Vanderburgh County Medical Society, is a five-minute discussion of the problems which arise in the daily doctor-patient

relationship. It includes such subjects as, "Why it is necessary to wait in a doctor's office," "Why it is advisable to discuss fees and services with your doctor in advance," "How to get a doctor in time of emergency." The programs are transcribed and will serve a double purpose. In addition to discussing the things which people complain about they will be played in society meetings and each subject will be discussed on the floor.

Wabash County Medical Society members met at the Honeywell Memorial in Wabash on March 12. Thirteen members were present to hear Dr. Warren C. Hastings, of Fort Wayne, speak on "Epilepsy."

Wells County Medical Society members met at the Caylor-Nickel Clinic in Bluffton on March 17, when a clinicopathological conference was held. A film was shown, also, on splenectomy for hemolytic anemia.

## WOMAN'S AUXILIARY TO THE AMERICAN MEDICAL ASSOCIATION

### PROGRAM of the TWENTY-NINTH ANNUAL MEETING

Chicago, Illinois, June 8-13, 1952  
Conrad Hilton Hotel

A cordial invitation is extended to all members of the Woman's Auxiliary to the American Medical Association, their guests and guests of physicians attending the convention of the American Medical Association, to participate in all social functions and attend the general sessions of the Auxiliary.

Headquarters will be at Conrad Hilton Hotel. Tickets will be available at the registration desk only. Please register early and obtain your badge and program.

#### Registration Hours

Sunday	-----	12:00 M	to	4:00 P.M.
Monday	-----	9:00 A.M.	to	4:00 P.M.
Tuesday	-----	9:00 A.M.	to	4:00 P.M.
Wednesday	-----	9:00 A.M.	to	4:00 P.M.
Thursday	-----	9:00 A.M.	to	12:00 M

#### PRECONVENTION SCHEDULE

##### Sunday, June 8

12:00 Noon to 4:00 P.M. REGISTRATION—Grand Ballroom Foyer (Mezzanine floor)—Conrad Hilton Hotel

The members of the Hospitality Committee will welcome members and guests of the Woman's Auxiliary

##### Monday, June 9

Round Table Discussions—Members Invited West Ballroom (third Floor)

9:00 A.M. to 10:00 A.M. Program—Mrs. Alfred F. Burnside, *Chairman*



## Radium Rental Service

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Organized for the purpose of making radium available to physicians to be used in the treatment of their patients. Radium loaned to physicians at moderate rental fees, or patients may be referred to us for treatment if preferred.

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- 10:00 A.M. Legislation—Mrs. Edgar E. Quayle, *Chairman*  
to  
11:00 A.M.
- 11:00 A.M. Public Relations—Mrs. Theodore E. Heinz,  
to  
*Chairman*
- 12:30 P.M.
- 2:00 P.M. Today's Health—Mrs. J. K. Avent, *Chairman*  
to
- 3:00 P.M. Fashion Tea—Marshall Field's Narcissus Room
- 3:30 P.M. Honoring Mrs. Harold F. Wahlquist,  
to  
President, and Mrs. Ralph Eusden,  
President-Elect. Invited guests: Members of the Board of Directors, State Presidents and Presidents-elect, wives of A.M.A. Trustees and Officers, Auxiliary Officers and chairmen, and wives of State and County Medical Societies Officers. (Illinois)
- 5:30 P.M.
- All wives of physicians are cordially invited
- Hostesses: The Woman's Auxiliaries to the Illinois State and Chicago Medical Societies
- Tickets \$1.50 (tax and gratuity included)

Borzell, Speaker, House of Delegates; Dr. James Reuling, Vice Speaker; Dr. Austin Smith, Editor; Dr. Joseph Lawrence, Director, A.M.A. Washington office; and the members of the Advisory Council of the American Medical Association to the Woman's Auxiliary.

#### Thursday, June 12

- 9:00 A.M. General Session of the Woman's Auxiliary to the American Medical Association, Grand Ballroom. Mrs. Harold F. Wahlquist presiding
- 7:00 P.M. Annual Dinner of the Woman's Auxiliary to the American Medical Association for members, husbands and guests, Crystal Ballroom, Blackstone Hotel. Tickets \$5.75 (tax and gratuity included). Dress optional
- Presiding, Mrs. Henry L. Schmitz
- 9:00 P.M. Reception and Ball in honor of the President of the American Medical Association, Palmer House.

### CONVENTION PROGRAM

#### Tuesday, June 10

- 9:00 A.M. Formal opening of the Twenty-ninth Annual Meeting of the Woman's Auxiliary to the American Medical Association, Grand Ballroom (Mezzanine floor) Conrad Hilton Hotel, Mrs. Harold F. Wahlquist, President, presiding
- 12:30 P.M. Luncheon in honor of the Past Presidents of the Woman's Auxiliary to the American Medical Association, Boulevard Room (North Mezzanine). Tickets \$3.50 (tax and gratuity included)
- Mrs. Harold F. Wahlquist, President, presiding
- Guest Speaker: Dr. Laurence M. Gould, President, Carleton College, Northfield, Minnesota
- 8:00 P.M. Opening Meeting of the American Medical Association, Palmer House
- Members of the Woman's Auxiliary and guests are cordially invited

#### Wednesday, June 11

- 9:00 A.M. General Session of the Woman's Auxiliary to the American Medical Association, Grand Ballroom (South Mezzanine), Mrs. Harold F. Wahlquist, presiding
- 12:30 P.M. Annual Luncheon in honor of Mrs. Harold F. Wahlquist, President, and Mrs. Ralph Eusden, President elect, Boulevard Room (North Mezzanine). Tickets \$3.50 (tax and gratuity included)
- Mrs. Frank N. Haggard, Past President, presiding
- Guests of honor: Dr. John W. Cline, President, American Medical Association; Dr. Louis H. Bauer, President-elect; Dr. Dwight Murray, Chairman, Board of Trustees; Dr. George F. Lull, Secretary and General Manager; Dr. Ernest B. Howard, assistant secretary; Dr. J. J. Moore, Treasurer; Dr. F. F.

### INDIANA STATE BOARD OF HEALTH

#### Division of Communicable Disease Control

#### MONTHLY REPORT—FEBRUARY 1952

Disease	Feb. 1952	Jan. 1952	Dec. 1951	Feb. 1951	Feb. 1950
Brucellosis	1	0	1	1	0
Chickenpox	605	489	389	358	363
Conjunctivitis	2	0	2	1	1
Infectious diarrhea	12	12	0	0	0
Diphtheria	3	3	5	2	24
Dysentery,					
Amebic	3	0	2	0	3
Virus	17	16	1	0	0
Encephalitis	2	3	1	2	2
Impetigo	2	7	2	1	0
Influenza	1105	67	46	64	37
Infectious hepatitis	49	24	22	11	17
Measles	951	849	440	624	676
Meningitis,					
Unclassified	9	3	7	5	8
Influenzal	1	1	0	2	0
Meningococcal	4	2	1	3	1
Mumps	660	537	288	182	161
Paratyphoid fever	1	0	0	0	0
Pneumonia	41	96	44	42	32
Poliomyelitis	6	3	11	4	2
Rabies in animals	12	12	27	49	55
Rubella	67	31	20	12	52
Streptococcal infections,					
Scarlet fever	409	190	182	233	210
Septic sore throat	12	3	4	0	0
Erysipelas	2	3	2	1	3
Tetanus	1	0	1	2	0
Tinea capitis	2	1	0	5	0
Typhoid fever	3	2	1	4	3
Vincent's angina	4	4	0	0	1
Whooping cough	34	86	108	97	157
Trichinosis	1	2	2	1	0



# protein?

# 60%

*yet as acceptable to the patient  
as a tasty milk shake*

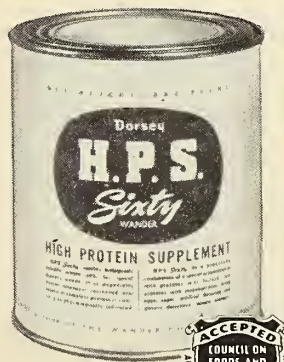
When the protein intake must be increased beyond the amount an acceptable diet can supply, **H.P.S. Sixty** proves especially valuable. Providing 60% protein, 1.5% fat, and 27% carbohydrate, it makes a delightful beverage with water or milk, readily acceptable to the patient even when anorexia prevails.

Prepared with water according to directions (6 oz. water, 1½ oz. **H.P.S. Sixty**), three servings daily furnish 77 Gm. of biologically complete protein. When skim milk or whole milk is used instead of water, three servings provide 96 Gm. or 95 Gm. of protein respectively.

**H.P.S. Sixty** is processed from milk protein concentrate, soy protein, whole egg powder, powdered sugar and flavoring. Its proteins are intact; hence it is not burdened by objectionable odor. Valuable for use when whole protein can be utilized, **H.P.S. Sixty** may be indicated in the dietary management of under-nutrition, peptic ulcer, hepatitis, chronic diarrheal states, pregnancy and lactation, and following burns and other injuries which raise the protein needs. Caloric equivalent, 3.6 per Gm., 102 per ounce.

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## H.P.S. Sixty

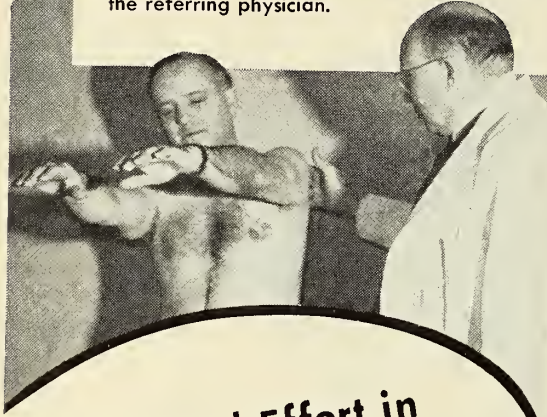


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At all times the regimen of treatment is well coordinated under the direction of a staff of experienced full-time physicians who are members of the American Medical Association.

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[ This is the second of a series describing the successive steps in the treatment of the "Problem Drinker." ]

Complete information, including rates, will be furnished to physicians on request.

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## Books

Books received are acknowledged in this column, and such acknowledgment must be regarded as a sufficient return for the courtesy of the sender. Selections will be made for more extensive review in the interests of our readers and as space permits. Books listed in this department are not available for lending. Any information concerning them will be supplied on request.

**DYNAMIC PSYCHIATRY, Basic Principles.** Volume One. By Louis S. London, M.D., New York and Washington. 98 pages. Price \$2.00. Corinthian Publications, Inc., New York 16, N. Y., 1952.

**INTRODUCTION TO MEDICAL SCIENCE.** By Julius Jensen, Ph.D. (In Medicine) University of Minnesota, and Henry W. Noller, M.D., Associate St. Luke's Hospital, St. Louis. 533 pages, 71 figures. Price \$5.75. The C. V. Mosby Company, St. Louis 3, Missouri.

**A TEXTBOOK OF CLINICAL NEUROLOGY WITH AN INTRODUCTION TO THE HISTORY OF NEUROLOGY.** By Israel S. Wechsler, M.D., Clinical Professor of Neurology, Columbia University, New York. New 7th Edition. 801 pages, with 179 figures. Price \$9.50. W. B. Saunders Company, Philadelphia 5, Penna., 1952.

**DOCTORS IN BLUE:** The Medical History of the Union Army in the Civil War. By George Worthington Adams, Dean and Professor of History, Colorado University. 253 pages; illustrated. Price \$4.00. Henry Schuman, Inc., Publishers, 20 East 70th Street, New York 21, N. Y. 1952.

**RHEUMATIC DISEASES**—Based on the Proceedings of the Seventh International Congress. Prepared by the Committee on Publications of the American Rheumatism Association: Charles H. Slocumb, M.D., chairman. Postgraduate Medicine and Surgery series. 449 pages with 126 figures. Price \$12.00. W. B. Saunders Company, West Washington Square, Philadelphia 5, Pa. 1952.

**A TEXTBOOK OF ORTHOPEDICS** with a Section on Neurology in Orthopedics. By M. Beckett Howarth, M.D., Clinical Professor of Orthopedic Surgery, New York University Post-Graduate Medical School, and others. 1110 pages with 463 figures. Price \$16.00. W. B. Saunders Company, West Washington Square, Philadelphia 5, Pa. 1952.

**PRESCRIPTION FOR MEDICAL WRITING**—A Useful Guide to Principles and Practice of Effective Scientific Writing and Illustration. By Edwin P. Jordan, M.D., and Willard C. Shepard. 112 pages with 26 figures. Price \$2.50. W. B. Saunders Company, West Washington Square, Philadelphia 5, Pa. 1952.

**TEXTBOOK OF REFRACTION:** By Edwin Forbes Tait, M.D., Ph.D., Associate Professor of Ophthalmology, Temple University School of Medicine; Attending Surgeon (Ophthalmology), Temple University and Montgomery Hospitals. 418 pages with 93 figures. Philadelphia & London: W. B. Saunders Company, 1951. Price \$8.00.



## BOOK REVIEWS

**ANTIBIOTIC THERAPY.** By Henry Welch, Ph.D., Director; and Charles N. Lewis, M.D., Medical Officer; Division of Antibiotics, Food and Drug Administration, Federal Security Agency of the United States Government. 562 pages, numerous figures; price \$10.00. The Arundel Press, Inc., P. O. Box 2606, Washington 13, D. C., 1951.

This work contains an authoritative account of the development of antibiotics which many physicians, even though they witnessed these developments from a distance, will be interested in reading. The life history of the discoverer of each antibiotic at the beginning of chapters is of particular interest. The scientific treatment of each of the antibiotics is thorough and includes data on antimicrobial activity, pharmacology, and dosage forms. References are listed at the close of each chapter. Following the detailed consideration of each of the now established antibiotics which occupy about one-half of the 542 pages of text, there are chapters which give clinical characterizations of the various infections, following which there is discussion of the modern methods of treatment. The authors have utilized the extensive literature and include other types of therapy when indicated.

This book will be of great value to all concerned with treatment of infections from both the practical and experimental standpoints. It is a rich source of up-to-date information on the subject.

C. G. C.

#### HOW TO IMPROVE YOUR SEXUAL RELATIONS.

By Edwin W. Hirsch, M.D., Noted Urologist and Associate Editor, International Journal of Sexology. 64 pages, cross-indexed for quick reference, booklet is written in lay language for prescription by doctors only. Price special for first edition \$1.00 for 2 copies. Zeco Publishing Co., 327 W. Madison Street, Chicago 6, Ill., 1951.

This is the second book on the subject of sex which the author has written this year. The subject of the book is indeed intriguing and should attract general interest. This paper-covered booklet contains much well written and frankly stated information. Such information regarding sexual relations should be available to married couples, persons anticipating marriage, and especially couples who are having some sexual difficulties. All of the material of the book has been previously written in other sex manuals. This manual has a table of contents, a glossary and a chapter index.

The book has been written to sell in drug stores on a physician's prescription. This method of distribution can be highly objectionable since it probably would eventually be sold promiscuously. Making such material available to younger individuals would be highly undesirable. Such literature should be dispensed by the physician to proper persons to supplement his personal advice.

D. A. B.

## Migraine In Children

"Migraine may appear during the first years of life. The presence of subjective signs, such as headache and flimmer scotoma, is often difficult to determine in young children. The true nature of the symptoms frequently remains obscure for years."

Vahlquist, B. and Hackzell, G.: *Acta Paediatrica* 38: 622 (1949).

NO. OF CASES	SEX	AGE AT ONSET	CYCLIC VOMITING	DURATION OF ATTACK	INTENSITY
31	8 ♀ 23 ♂	3 yrs. (mean)	3 out of 31	2½ hrs.	severe in all cases

TABLE CONT'D

NO. OF CASES	UNILATERAL HEADACHE	NAUSEA	FLIMMER SCOTOMA	VERTIGO	HEREDITY
31	18 out of 31	31 out of 31	12 out of 31	6 out of 31	20 out of 31

(reference given above)

In a study of 400 adult migraine patients, it was revealed that 34% had suffered attacks before the age of 15.\* These investigators concluded that childhood migraine was a much greater clinical problem than was previously believed and that psychodynamic mechanisms played an important part in the disease.

These criteria are useful in diagnosis:

Headache attacks with symptom-free intervals plus (at least two of the following) nausea, scintillating scotoma, hemicrania, and hereditary predisposition.

For symptomatic relief in these cases, **Cafergot®**, N.N.R. (ergotamine with caffeine) may be administered orally. For best results, give adequate dosage promptly.

For children within the age range 7 to 12 years—**Cafergot®** is administered, one tablet when the attack appears imminent followed by one additional tablet within 30 minutes. Not more than two **Cafergot** tablets should be administered to children within this age range.

In the adolescent age group, 12 to 18 years of age, the dosage may gradually be increased as necessary up to the usual adult dose, i.e., two tablets when the attack appears imminent followed by one tablet doses at half hour intervals until the attack is aborted. (*Total maximum dose for adults: six tablets for each attack.*)

\*Katz, J., Friedman, A.P., and Gisolfi, A.: New York State J. Med. 50: 2269 (Oct.) 1950.

**Sandoz Pharmaceuticals**

DIVISION OF SANDOZ CHEMICAL WORKS, INC.  
68 CHARLTON STREET, NEW YORK 14, N. Y.

## BOOKS REVIEWED

**"THE SERPENT-WREATHED STAFF"**—a novel by Alice Tisdale Hobart.

If Mrs. Alice Tisdale Hobart had managed to devise a suitable ending for her 402-page novel, "The Serpent-Wreathed Staff," about sixty pages sooner than she did, a tolerant critic would be able to say that she had written a faulty but highly interesting story of human conflicts and loyalties.

Unfortunately, however, the latter part of the book degenerates swiftly and recklessly into an amazing propaganda piece for National Compulsory Health Insurance. This uncraftsmanlike abuse of artistic license, added to some of the implications built up in earlier pages, creates the impression that the entire novel was designed as a subtle presentation of the case for Socialized Medicine. As a result, Mrs. Hobart undermines much of the validity that does exist in some of the earlier parts of this book about doctors, modern medicine and a changing world.

She is at her best when describing the personal problems and struggles, the emotional triumphs and defeats, of her principal characters. On this fictional level the book has undeniable merit and strength, for the reader finds himself sharing the fears, anxieties and grief of the people in the novel.

Central figures in the story are two brothers, Dr. Alan Towne and Dr. Sam Towne, grandsons of old Dr. Samuel Towne, who had achieved medical eminence only after many years of struggle and criticism because of his unorthodox ideas. Sam, the older of the two brothers, is portrayed as successful, wealthy, conservative. Alan is drawn as idealistic, progressive pioneer, striking out in new and dangerous directions and carrying on in the tradition of his grandfather.

Main action of the novel begins shortly after the end of World War II when Alan leaves a comfortable, assured partnership with Sam to start a group practice. From then on the troubles and tragedies mount in rapid sequence and growing complexity. In the short space of three or four years Alan becomes an "Anthony Adverse" in modern American medicine.

When the facile, all-inclusive plot is used as a mechanism for discussion of the social, economic and political aspects of modern medicine, the book suffers not only from the standpoint of literary merit but also from the standpoint of accurate reporting. On this level the book is dangerously superficial. Complex problems and issues affecting the practice of medicine are introduced, but mixed with just enough truth and half-truth to give credence to a distorted picture.

As all of these elements are woven deftly into the novel, their manner of presentation builds the

subtle implication—even in the earlier parts of the book—that most doctors are primarily and selfishly interested in making money, bolstering their own reputations and preserving the status quo in medicine.

Mrs. Hobart also gives the impression that group practice, health insurance plans, preventive medicine and similar ideas are brand new developments—practically untried and unheard of in a present-day American city. Actually, most of the concepts and projects which occur to Alan Towne, in sudden flashes of inspiration, are part of the knowledge of any alert medical student. Actually, the industrialists and businessmen on Alan's hospital board are utterly untypical when they talk and act as if they had never heard of such a thing as group health insurance for their employees.

Before Mrs. Hobart writes another novel on this subject, someone should familiarize her with the major facts and realities in the field of modern medical economics.

Someone, for example, should tell her about the many famous clinics and countless other forms of group practice which are in successful operation throughout the country, some of them since around the turn of the century.

Someone should tell her about the hundreds of fast-growing, constantly-improving Voluntary Health Insurance plans, which by the end of this year will be protecting an estimated 90 million Americans against the major costs of illness and accidents.

Someone should tell her about the Nationwide progress of State and County Medical Societies in setting up doctor placement programs, grievance committees, emergency call systems, cost adjustment committees, local health units and a variety of other activities designed to make good medical care available to all the people.

Incidentally, someone also should inform Mrs. Hobart that the "National Medical Association," a name she uses as a pseudonym for the American Medical Association, is the actual and proper name of the National organization of Negro physicians.

Everyone interested in American medicine, and in the effort to find intelligent solutions to our medical care problems, should read "The Serpent-Wreathed Staff"—if for no other reason than to help repair the damage which the book does.

Read simply as a novel, it is a moving, absorbing story. Read as a source of information affecting public opinion on medical-economic issues, it unfortunately is an example of careless, superficial writing, with a built-in conclusion contrary to the convictions of the great majority of Americans today.



## BOOKS REVIEWED

**STATISTICS FOR MEDICAL STUDENTS** and Investigators in the Clinical and Biological Sciences. By Frederick J. Moore, M.D., Associate Professor of Experimental Medicine, Frank B. Cramer, B.A., Research Fellow, and Robert G. Knowles, M.S., Research Associate. Department of Experimental Medicine, University of Southern California School of Medicine. 113 pages, 11 figures and 16 tables. The Blakiston Company, Philadelphia 3, New York 22, 1951.

The medical student and medical researcher who will take the time to study this little book carefully will be well rewarded. The authors have given a particularly fine discussion of some of the philosophical concepts underlying modern statistical techniques. The discussion of the "ultimate determinants of variation" is especially well done, as is the final chapter which is concerned with the definition of the purpose of an experiment and the importance of being able to "clearly specify the generalization which the experimental data will allow him to accept or reject." The reader who takes the trouble to assimilate fully these philosophical ideas will have gained a tremendous amount from this book even though he may have some difficulty with the more mathematical parts of it. This latter is not because the authors are not clear in their presentation, but merely that, in the reviewer's experience, the statistical concepts presented call for consider-

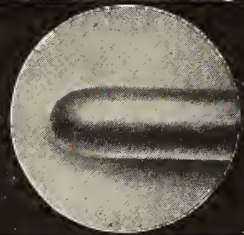
able reorientation of thinking on the part of the ordinary medical student. A somewhat more gradual introduction to some of these statistical topics is afforded by Bradford-Hill's **Principles of Medical Statistics** which, in combination with the present book, should be ideal for giving the researcher and the student the tools which he needs and an understanding of their uses and their limitations.

The first chapter begins with a discussion of the nature of variation. This leads to the point binomial and its approach to the normal curve. This is followed in the second chapter by the usual discussion of the mean and the standard deviation. A brief discussion of curve fitting is included in this chapter, as well as the consideration of the statistical approach to dosage-responses. The third chapter is concerned with sampling distributions and tests of significance; and the next to the last chapter considers the problems raised by non-normal distributions. The fifth and last chapter is concerned with the general aspects of the design of experiments and the presentation of results. As indicated above, this chapter is an especially good one and should be read carefully by every researcher in the medical sciences.

PAUL M. DENSEN, Ph.D.

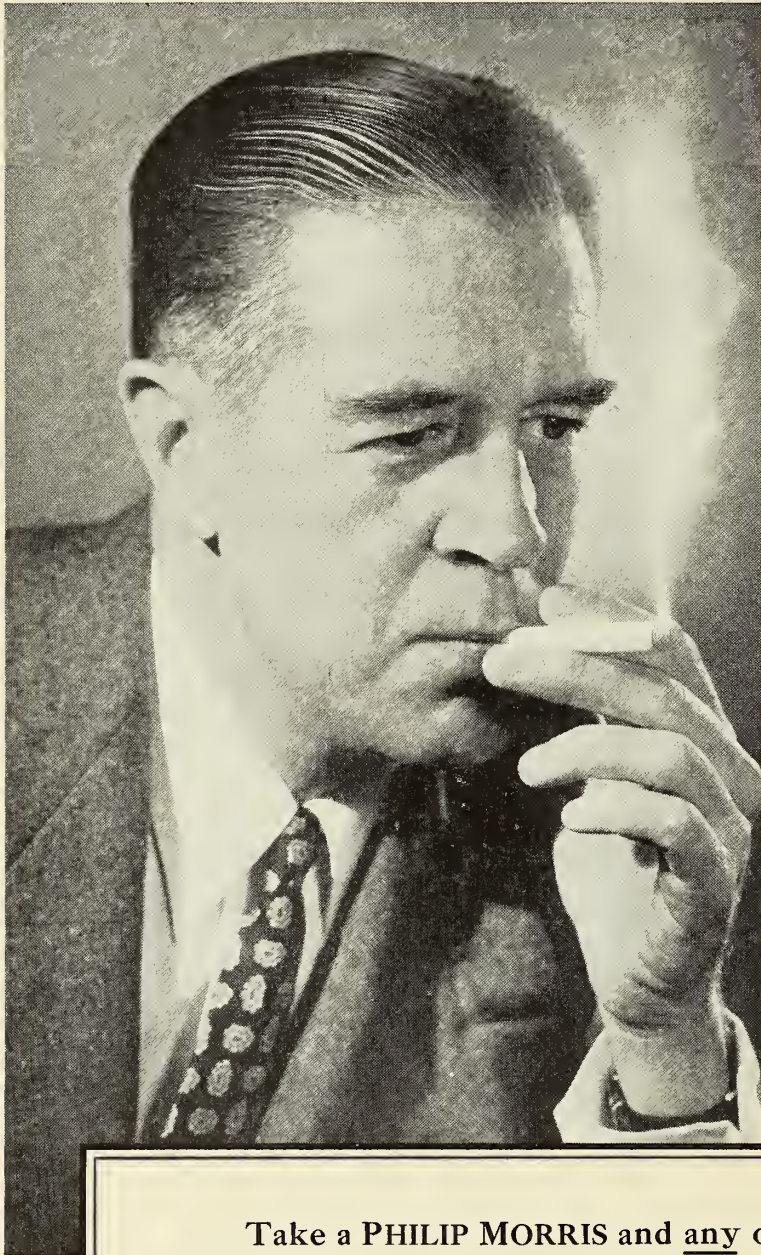
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### THE ROLE OF ACTH AND CORTISONE IN THE TREATMENT OF SHOCK†

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THE endocrine defense of the body to trauma has long been believed to lie in the adrenal gland. Historically, our concept of the role of this gland may be divided into three periods. It was the medulla which first received attention; the autonomic nervous system was found to respond to an alarm by stimulating the adrenal medulla through the splanchnic nerves to secrete epinephrine. This role of the nervous system and adrenal medulla was summarized in 1915 and 1929 by Cannon in his classic monograph entitled, "Bodily Changes in Pain, Hunger, Fear, and Rage."<sup>1</sup>

The second period was opened in 1934 when Swingle and his colleagues, in describing adrenal cortical insufficiency in the dog, pointed out the similarity to traumatic shock, and thus brought the cortex of the gland to the forefront.<sup>2</sup> The role of the medulla had not overly impressed

the experimenter or clinician studying shock. The effect of epinephrine was too evanescent. Cannon himself believed the secretion of epinephrine to be but intermittent and for temporary emergency only. Animals with the medulla destroyed survived in apparent health. But the cortex—here was something different. The possible role was impressive and many became interested.

It was not until 1944 and 1945 that Marthe Vogt in London<sup>3</sup> and Long in New Haven,<sup>4</sup> working independently, integrated these two anatomic and physiologic parts of the adrenal gland into sequential phases of a single alarm, initiating the third period of our understanding. Epinephrine was discovered to stimulate an increased output of hormone from the cortex. The increased cortical output proved to be mediated indirectly through ACTH released from the anterior pituitary. Thus, the quick acting epinephrine, an immediate endocrine response to alarm, soon finds support, a line of secondary defense, in the slower and longer acting cortical hormones. This integration of the two phases

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† An address read at the Symposium on Shock at the Army Medical Service Graduate School on May 8, 1951.

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of the adrenal alarm gives substance to the earlier physiologic ventures. The understanding has been further extended by the studies of Harris and Hume,<sup>5,5a</sup> indicating that centers of the brain may directly stimulate the anterior pituitary to release ACTH.

The recent advent on the drug market of the two powerful hormones, ACTH and Cortisone, is perhaps carrying us into a fourth period of understanding of the adrenals in shock. They are more potent than the extracts, and have a wider and perhaps more physiologic effect than that of desoxycorticosterone. Their effect on certain medical diseases has been striking. The reported benefit of ACTH in burns<sup>6, 7</sup> is motivating a mighty surge of use of these hormones in the treatment of burns, and we may well expect their use to spread to treatment of various forms of shock. Hampered by lack of knowledge of the primary actions of the cortical hormones, we are forced by this burst of enthusiasm to assemble what knowledge we possess, appraise the role of the adrenal cortex in the response to trauma, and advocate if we can the proper use of these hormones in therapy.

Centering attention upon the cortex of the gland, I would like to go back once again to the work of Swingle and his colleagues. Having found similarities between the cortically insufficient dog and the dog in shock from various forms of trauma, these investigators turned their attention to the effectiveness of the adrenal hormone in preventing or relieving shock. They confirmed an earlier finding of others that the adrenalectomized animal was exquisitely sensitive to shocking procedures such as hemorrhage, intestinal stripping, and muscle pounding. They demonstrated that the adrenalectomized dog which had been primed with adrenal cortical extract or desoxycorticosterone acetate (DCA) in doses much greater than those needed for the maintenance of the animal, resulted in a return of resistance to the shocking procedures equal to that of the normal dog.<sup>8</sup> They were unable, however, by comparable priming with extract or DCA to increase the resistance of the intact, non-adrenalectomized dog to the shocking procedures.<sup>9, 10</sup> Other investigators, using both adrenal extract and DCA, have been able to their satisfaction to increase the resistance of experimental animals and of patients to various shocking procedures. Time does not permit a

review of what has now become a large literature. Excellent reviews are available.<sup>10, 11, 12</sup> I shall summarize it, however, by saying that it is conflicting and confusing. Claims of benefit from the use of adrenal cortical extract or DCA are based upon a few experiments or clinical experiences. One of the papers advocating the use of extract in clinical burns has been retracted by a second paper from the same authors.<sup>13, 14</sup> In many other instances optimism and enthusiasm seem to have overrun sound criticism.

### Evidence of Adrenal Cortical Role in Trauma

In the past ten years abundant evidence has accumulated indicating that an increased output of adrenal cortical hormone is a normal response to trauma. The evidence is both direct and indirect. The following five observations constitute direct evidence:

1. The adrenalectomized animal, receiving a maintenance dose of cortical replacement therapy, stands shocking procedures poorly. Such animals, if primed with an increased amount of cortical hormone, can withstand the shocking procedures better; that is, the animals are less hypersensitive.<sup>10</sup>
2. Patients with Addison's disease, receiving a dose of adrenal hormone adequate for normal life, require an increased dose of hormone if undergoing an operation, are injured, become infected, or are otherwise exposed to stress.<sup>15</sup>
3. Patients with Cushing's disease, a disease with overfunction of the adrenal cortex, pass through operative procedures smoothly so long as the hyperfunction is not interrupted by the operation. When the operation is on the adrenal and reduces the amount of functioning tissue to the normal requirement, the patient has an inadequate amount of hormone to carry him through the immediate postoperative period, and requires a hormonal supplement for two to four days.<sup>16</sup>
4. Experimental animals, receiving repeated traumatic insults, develop adrenal cortical enlargement.<sup>17</sup>
5. Patients with burns and prolonged infection and multiple traumatic insults such as operations, also develop adrenal cortical hypertrophy.<sup>16</sup> An occasional burned patient, with prolonged infection of the wound, develops signs



of Cushing's disease. Amenorrhea in women, a moon face, hirsutism, and occasionally striae and capillary fragility have been observed.<sup>17</sup> In the days before modern antibiotics, long eyelashes and embarrassing hirsutism were common features of women afflicted with chronic empyema or other long standing, active infections.

The following evidence pointing to an increased activity of the adrenal cortex following traumatic insult is more indirect.

6. The drop in lipoid and Vitamin C content of the adrenal cortex following various traumatic procedures and epinephrine.<sup>18</sup>

7. The patterns of urinary hormonal excretion following trauma. J. S. L. Browne of Montreal was the first to appreciate the increases of hormonal output through the kidney following major fractures and burns and to tie the hormones to adrenal action.<sup>19</sup> His initial observations have been amply confirmed by John E. Howard,<sup>20</sup> Nathanson and myself,<sup>16</sup> Albright,<sup>21</sup> Talbot,<sup>22</sup> and many others. Browne showed that the hormone protecting the adrenalectomized animal against cold is one of those increased. The 17-ketones are also increased, but transiently. Talbot, in three of our cases, has demonstrated a rise in the 11-oxy to levels comparable to those in patients with active Cushing's disease. Nathanson has also disclosed an increase in estrogen in five of our burned patients comparable to that found in non-burned patients receiving ACTH.<sup>16</sup>

8. The metabolic response following trauma has been simulated by F. D. Moore in healthy volunteers by a combination of starvation and ACTH. Starvation alone does not recapitulate the picture of trauma.<sup>23</sup>

9. Conn, at Michigan, has shown that the electrolyte excretion pattern of sweat is altered by adrenal cortical function. After operation the sweat pattern changes to that associated with increased cortical function.<sup>24</sup>

10. The eosinophil level of the blood drops during operation, following burns and other trauma.<sup>16, 25</sup> Comparable drops are induced by adrenal hormone therapy. Although the adrenal cortex is not the only influence upon the eosinophil level of the blood, it is believed to be a major influence; general experience is in agreement. Recently, Evans and Butterfield have demonstrated in burned patients a correlation

between the depth and duration of fall and the extent of the burn.<sup>26</sup>

### Should the Spontaneous Adrenal Cortical Response be Fortified?

Having established that an increased activity of the adrenal cortex is a part of the normal response to trauma, the question arises whether this response should be fortified by ACTH or Cortisone, or whether it should be tempered by an anabolic hormone such as testosterone. In order to answer this question, it is first necessary to define the normal response, second to learn the purpose of the response, and third to know whether when uninhibited it is adequate or inadequate.

The normal uninhibited response of the adrenal cortex to trauma is still short of definition. In experiments with animals, where methods of examination are less confined and where the identical experiment may be repeated innumerable times, the reaction is susceptible of more succinct description. In patients who have been injured or exposed to a trauma such as operation, the number and type of examinations which can be made are limited and the number of variables introduced by chance circumstance retards definition. To illustrate this variation, I will confine my remarks to the response seen in burns; it is in the field of burns that I have had my biggest personal experience.

The purpose of the adrenal cortical response to trauma is far from clear. This should not surprise us because we know little as yet of the physiologic and almost nothing of the biochemical actions of the adrenal cortical hormones. We have concepts of adrenal cortical action, but we are still confronted by the conflicting evidence.

One concept of interest to the shock problem is that the cortical hormones fortify the circulation. Certain it is that hypotension is an accompaniment of cortical insufficiency while hypertension is a common accompaniment of Cushing's disease and of overdosage of ACTH and Cortisone.

Another concept is that the hormones influence capillary permeability. In 1940, using the Drinker lymph preparation in dogs, I thought I had disclosed evidence of increased capillary permeability in the adrenally insufficient animal.<sup>27</sup> Further experimentation has led me to

the conclusion that my original deductions were wrong. There seems to be no direct action of the hormone on the capillary membrane of the dog's foot. I will discuss later the lack of action on the capillary membrane damaged by heat.

Cell permeability in general as a site of action has been a favorite theory. Direct evidence testing this point is difficult to obtain, and the indirect evidence which is available is equally well explained by alterations in intermediary metabolism.

The response to trauma appears to be an integral part of the reaction of the healthy person. The need of the patient with Addison's disease for an increased dose of hormones after trauma or unusual stress suggests that there may well be other conditions which should need supplementary adrenal cortical therapy. These conditions might exist before the trauma or develop as the result of a complication.

John E. Howard has described the failure of the negative nitrogen balance to appear in depleted patients who were subjected to trauma.<sup>20</sup> His patients, who had fractured femurs, had previously been in bed for other reasons. The negative nitrogen balance which normally follows such a fracture did not appear. We have encountered this absence of the negative nitrogen balance in two severely burned patients.<sup>16</sup> One of them had been confined to bed with tuberculosis for three months before being burned. The other was a severe chronic alcoholic in poor nutritional state. Both of them were in positive nitrogen balance from the time of their admission immediately following the burns until healing and discharge from the hospital. There is no evidence that the adrenal cortical response was deficient in these patients.

It has long been held by some that the adrenal cortex undergoes disintegration following trauma. Believing that the adrenal cortex might well suffer damage comparable to that suffered by the kidney from anoxia during a hypotensive phase of shock,<sup>28</sup> we have recently reviewed the adrenal cortices of all our patients of the last few years who died acutely following burns. To our disappointment, there is a paucity of positive findings. The adrenals of those patients, who on clinical grounds might have suffered from some degree of cortical insufficiency, showed few or no recognizable changes from the normal. It is, of course, possible that the histologic methods

of examination at present available are inadequate for the task. What we have found in patients dying of burns has been reported by others for other forms of trauma. Except for patients with primary Addison's disease and hypopituitarism (in which there is an element of hypocortinism), we have not as yet been able to recognize with finiteness and clarity any group of patients who fail to make a normal adrenal cortical response. Perhaps patients with primary myxedema will be such patients, or with diabetes mellitus. The great variability among the normal controls, however, makes it difficult to define such patients with deficient responses.

There are two other possible approaches which may be tried to answer the question of whether adrenal cortical hormones should be a part of our therapy for shock. Both of these approaches involve the use of ACTH and Cortisone.

The first approach is a general clinical trial of these hormones in the prevention or therapy of shock in the post-traumatic phase. This is the approach used by Whitelaw in treating the farm hand burned in Arizona last July. The publicity which has been given this case has resulted in a widespread use of the approach all over this country in other patients with burns.

This approach is hit or miss, and it is doubtful whether we will obtain critical data. There are too many variables involved for accurate and critical statistical analysis. The effects of the hormone therapy are not sufficiently outstanding as was the case with the introduction of the sulfonamides and penicillin for us to be sure on the basis of clinical impression. By the time enough cases have been treated for statistical purposes, other aspects of the therapy will have been altered and any statistical analysis will be questionable. At the present writing it appears unfortunate that the gullible medical public has already plunged into this approach with so little hope for a conclusive outcome.

The second approach employing a therapeutic trial of these hormones is that in which a critical physiologic examination is made of one aspect of the disorder. Let me illustrate this approach in relation to burns. It can be employed both in experimental and clinical research.

Burn shock is due to the loss of an adequate circulating plasma volume. The heat damages capillaries and increases the permeability of their



walls so that a protein-rich plasma filtrate streams out into the burn wound. The wound swells with edema, and as it swells the plasma volume diminishes.

Whitelaw claims that ACTH dries the burn wounds, and, therefore, precludes or diminishes the need for plasma therapy to replenish the circulating blood volume. If this claim is true, then burn wounds should stop swelling once ACTH therapy is started. That swelling which has occurred should be resorbed more quickly.

Let us show you how we have examined this claim.

The wounds of burned patients treated with ACTH have developed measurable edema and blebs of the same extent, duration, and protein concentration as comparable wounds in non-treated patients. The examinations were as follows:

1. By observing burned patients, timing the development and resorption of edema. An elderly woman entered the hospital three hours after an extensive flame burn of the upper extremities, upper chest, head, and neck. She was started immediately on ACTH and given plasma, electrolyte, and water therapy according to the surface area formula. The urine initially was discolored with the products of hemolysis, but good renal function was maintained. During the first 36 hours after injury, the burns of the face continued to swell in fashion similar to comparable burns of non-treated patients. The eyes were nearly occluded and the lips bulbous. The peak of edema was reached about the 36th hour. After the 48th hour, edema resorption was rapid and nearly as quick in disappearing as in its formation.

2. The edema formation and resorption has been measured by means of a plethysmograph. The chance burns of the dorsum of the hand and wrist of four patients have been so measured. All four patients were active adult males; the burns were flash burns. The arms above the wrists had been protected by the coats. The total burns were of such limited extent that specific fluid therapy was not required. Two of the patients were treated with ACTH and two served as controls. The period of edema formation and edema resorption were essentially identical in all four patients. It so happened that the actual quantitative volume changes in all

four were approximately equal because the burns were of similar distribution. The quantitative volume changes are not the important issue; it is the period occupied in developing the edema, the slope of edema rise, the time at which peak edema was reached, at which resorption began, and the slope of resorption. If ACTH had influenced the healing of the capillaries for the good, then the peak of edema should have been reached sooner and resorption started earlier. There were no recognizable differences between the four patients.

3. Bleb fluid analyses made at varying intervals following injury revealed protein concentrations comparable to those encountered in controls at similar periods after injury. Early capillary healing should have resulted in lesser protein concentrations.

4. Two patients with active Cushing's disease due to hyperfunctioning adrenal cortical tumors who volunteered to submit to controlled experimental burns developed the same edema and blebbing as did normal human volunteers similarly burned.

The effectiveness of ACTH in eliminating the increased capillary permeability, and, therefore, the need for fluid therapy has also been tested in experimental animals.

5. Pairs of young hogs were burned by controlled technique, each pair with a comparable set of burns of varying intensity. One of each pair was treated with ACTH. No difference in edema or blebbing could be ascertained between the treated and non-treated members of the pair.

6. The Drinker dog foot lymph preparation has also been used. Neither ACTH nor Cortisone has influenced the rate and volume of edema formation or the rise in flow and protein concentration of lymph following a hot water burn of 90° C. for ten seconds.

These observations do not substantiate the claim that ACTH precludes or diminishes the need of the burned patient for plasma colloid, electrolyte and water therapy in the initial 36 hours after injury. We suspect that Whitelaw, and others, have confused the increased capillary permeability of infectious inflammation with that engendered by heat.

These observations on ACTH on the capillary permeability in burns cannot be considered con-

clusive and must be extended. Even if it is accepted that ACTH does not have sufficient effect on the healing of injured capillaries to be recognized by this approach, it does not mean that the adrenal hormone may not have an effect. Other observations on the patients and in some of the experimental animals indicate that the adrenals of patient and animal were making the response characteristic of a burn injury. It is possible that this response is maximal, and that the addition of exogenous ACTH can call forth no further output of adrenal hormone. These experiments are therefore being repeated using Cortisone; insufficient observations have been made at this time to warrant any statement.

These observations obviously do not permit an evaluation of these hormones in other aspects of burn therapy.

### Summary

The issues involved in the use of these drugs in the therapy of shock may best be summarized as follows:

#### *Summary of things established:*

1. An increased output of adrenal cortical hormones is a part of the normal response to trauma.
2. The adrenal hormones have something to do with the maintenance of blood pressure.
3. Addisonian patients need additional Cortisone therapy when traumatized or stressed.
4. There is no evidence that added adrenal cortical hormones beneficially affect the increased capillary permeability engendered by burns.
5. The adrenal cortical hormones cannot make blood constituents fast enough to offset hemorrhage from traumatic wounds or plasma loss from burns. They cannot, in other words, draw water from thin air.

*Summary of unsubstantiated claims:* It is claimed that the adrenal cortical hormones diminish pain and increase appetite.

*Summary of things not known which bear on therapeutic use:*

1. The physiologic purpose of the adrenal cortical response to trauma is not known.

Opinion is divided about the possible immunologic role in the defense against infection. It is possible that the adrenal cortical hormones are a factor in limiting or reversing the irreversibility of shock.

2. The adrenal hormones reduce fever. The meaning of fever to immune body production is little understood. The reduction of fever in the presence of infection may be beneficial or unwise.

#### *Summary of possible hazards:*

The possible hazards of ACTH or Cortisone therapy in shock are as follows:

1. ACTH and Cortisone therapy are followed by prompt increased excretion of potassium. The potassium is apparently released from tissues, and as long as kidney function is assured it is promptly excreted, and the level of potassium in the serum and extracellular fluid generally does not increase. Breed and Baxter in New York,<sup>29</sup> who have been studying renal function in shock, have called attention to the possible hazard of the use of the adrenal hormones in patients in whom renal failure is impending from shock or in whom renal damage has already resulted from the inadequate blood flow of shock. They warn against a possible abrupt rise in serum potassium to toxic levels.

2. These adrenal hormones have been found to limit certain types of infectious inflammation, certainly that engendered by the staphylococcus.<sup>16</sup> It is possible that the use of these hormones will open pathways to the spread of certain bacterias such as the staphylococcus and the streptococcus.

3. Acute psychoses are not a rare complication of therapy with these hormones in patients with arthritis, etc. We have encountered similar acute psychoses in three patients with active Cushing's disease. The psychoses have cleared slowly after stopping therapy or appropriate adrenalectomy.

4. Perforation of a duodenal ulcer has been a reported complication of ACTH or Cortisone therapy. We personally have heard of five, one of which occurred in a burn patient one month after injury. The hormone therapy masks pain and the signs of peritonitis. The known occurrence of Curling's ulcer following burns should



make us hesitate about the use of these hormones. Curling's type of ulcer is probably an equally common sequel of other forms of trauma, particularly in older males or those who have an ulcer history.

5. Following trauma, the body sets up a new set of priorities for endocrine function. The increased activity of the adrenal cortex is by no means the only change. It is almost certain that gonadal function ceases promptly. This is registered by amenorrhea in the female and impotence in the male. Gonadal function is for procreation, and presumably can be dispensed with when the body is threatened by trauma and the open wounds of burns. During the early phases of dehydration and electrolyte imbalance, it is reasonably certain that the posterior pituitary is overactive.<sup>30</sup> Although there is commonly a rise in oxygen consumption to high levels following burns, our studies using radioactive iodine tracers and protein-bound iodine of the serum indicate that the thyroid function remains normal.<sup>16</sup>

The use of doses of ACTH or Cortisone adequate to increase cortical activity will inevitably disturb the glandular balance which the body has set up following the trauma. If ACTH is injected, although the adrenal may be increasingly stimulated, the pituitary will be rested. If Cortisone is given, the adrenal may be rested but adrenotrophic activity of the anterior pituitary inhibited. The increased cortical activity will also depress thyroid function. A slightly depressed thyroid function is the rule in Cushing's disease, and similar depression has been demonstrated by Thorn, et al., to follow ACTH and Cortisone therapy.<sup>31</sup> Until we know the meaning of the total gland balance, such a disturbance may be unwise. It is well to recall that use of testosterone to diminish the negative nitrogen balance of the post-traumatic phase may also disturb the endocrine balance by anterior pituitary inhibition. Such testosterone therapy, recommended to diminish the nitrogen wasting, may to some extent counteract the expected adrenal response.

6. There is always a danger inherent in recommending a therapy of doubtful advantage. The mere fact that the therapy is recommended suggests that it is believed to have some useful purpose. The medical profession, unfortunately,

is not always sufficiently critical to look behind the recommendations. The hazard lies not so much in a possible deleterious action of these hormones as that the doctor will count upon them to do something and will not pay proper attention to other and proven aspects of therapy. This is already occurring in the burn field. We know of numerous instances where doctors who should be giving colloids and fluids and electrolyte therapy to extensively burned patients are giving ACTH, counting upon it to carry the ball. An uncritical recommendation at this juncture can be irresponsible.

### Comment

The present situation regarding the use of ACTH and Cortisone in shock may be likened to the man on horseback—lost, at night, and in a storm. This man does not know the country, but the horse does. Under the circumstances there is wisdom in giving the horse his head. Horse sense will enable him to find the way to the stable.

The man, of course, is the physician; the horse in the storm the traumatized patient. The stable represents recovery. The traumatized patient has a kind of horse sense. Since earliest infancy the patient has been subjected to traumas of one sort or another—falling out of the crib, the common cold, measles, a fright, a fracture, or an operation. He is well accustomed to alarm. Until our wisdom is at least the equal of his horse sense, we had better let the patient find his own road before we force him to turn to a different endocrine path.

We can do much to help the horse along the way to the stable. We can make sure he gets food and water. If we support the traumatized patient with adequate blood and other indicated replacement therapy, we will help his adrenals, like his kidneys and liver, to function adequately for his needs. This is indirect endocrine therapy.

Later, when our knowledge of our surroundings surpasses horse sense, we may well find a place to use ACTH and Cortisone for a deficiency here, a defect there, short cuts from the storm to the stable.

### Conclusion

A part of the healthy body's response to stress or trauma is an increased secretion of adrenal cortical hormones. The physiologic and immunologic purpose of this response remains obscure.

At the present writing there is no proven role for ACTH or Cortisone in the therapy of shock in patients who were well previous to a burn or other trauma.

In patients with known Addison's disease who are exposed to trauma, Cortisone is indicated in greatly increased doses.

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# MULTIPLE POLYPOSIS OF THE COLON

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**W**HAT is the correct treatment for multiple polyposis of the colon? The answer is a challenge to the modern surgeon.

In this disease the polyps are not present at birth, but begin to appear when the patient reaches puberty, and manifest themselves clinically usually in the second, third, and fourth decades. The symptoms, as a rule, are diarrhea, rectal bleeding, and abdominal cramps.

Multiple polyposis of the colon occurs about equally in the female as compared to the male, and a definite family history is obtainable only in approximately 50 percent of the cases. Generally the polyps are distributed throughout the colon and rectum, although once in a while the right colon may escape involvement.

Black<sup>1</sup> states the treatment has been standardized in his estimation; if adenocarcinoma is present in the rectum, local treatment is performed when feasible. If the carcinoma goes beyond the local area, a combined abdominoperineal resection followed by an ileostomy and total colectomy is indicated, performed in two or three stages. A single stage subtotal colectomy and ileosigmoidostomy is preferred when the rectum can be preserved, followed by frequent subsequent fulgurations of the lower sigmoid and rectum. The above procedure deviates from the more or less standard one of primary fulgurations followed by subtotal colectomy and ileosigmoidostomy. The reasons, however, appear sound, namely:

1. The exact site of the anastomosis cannot be determined before surgery; consequently, in many cases superfluous fulgurations may take place.
2. The colectomy has to be postponed for a few months to allow the acute inflammatory changes to subside.

3. The possible remaining inflammatory changes in the wall after fulgurations are to be seriously considered from the standpoint of leakage.

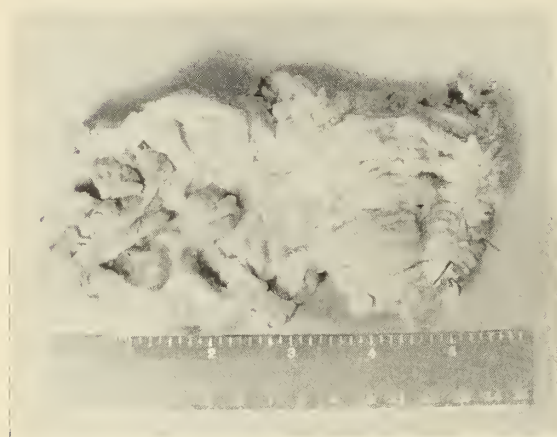
Ravitch<sup>2</sup> advocates a total colectomy with anal ileostomy and preservation of the anal sphincter in all cases of multiple polyposis of the colon, whether frank adenocarcinoma is present or not. In preserving the rectum, why do an extensive resection, and leave behind the very segment in which carcinoma most often develops?

Bartlett<sup>3</sup> recognizes this disease as a fatal one if not treated, or if inadequately treated. The only safe treatment is a permanent eradication of abnormal epithelium. He favors a two-stage abdominoperineal resection followed by total colectomy and ileostomy (Dragstedt type). This skin grafted ileostomy largely eliminates the horror and fear of the older type of ileostomies, and one becomes less reluctant to sacrifice the rectum.

Coffey<sup>4</sup> still favors the standard procedure of primary fulguration of all polyps in reach of the sigmoidoscope, followed by subtotal colectomy and ileosigmoidostomy. Regular sigmoidoscopic examinations with fulguration of recurring polyps is strongly advised after the operation.

Jones<sup>5</sup> felt the surgeon was always uncertain whether a carcinoma was present at the time of the examination, or whether one would develop during the course of surgical treatment. He felt that biopsies of the polyps were practically unnecessary, since a neoplasm might be developing anywhere throughout the colon or rectum. During his experience, few of the patients examined would submit to the definitive operation because of their reluctance to accept such a radical program.

FIGURE 1



**Rectum. Note central stricture and ulceration, as well as multiple polyps. No frank malignant change was found in any part of the rectal mucosa or wall.**

Boehme<sup>6</sup> presented a family in which six cases of multiple polyposis were found. He favors the one-stage subtotal colectomy with ileosigmoidostomy, followed by a rigid regimen of checkups and application of the "suction cautery."

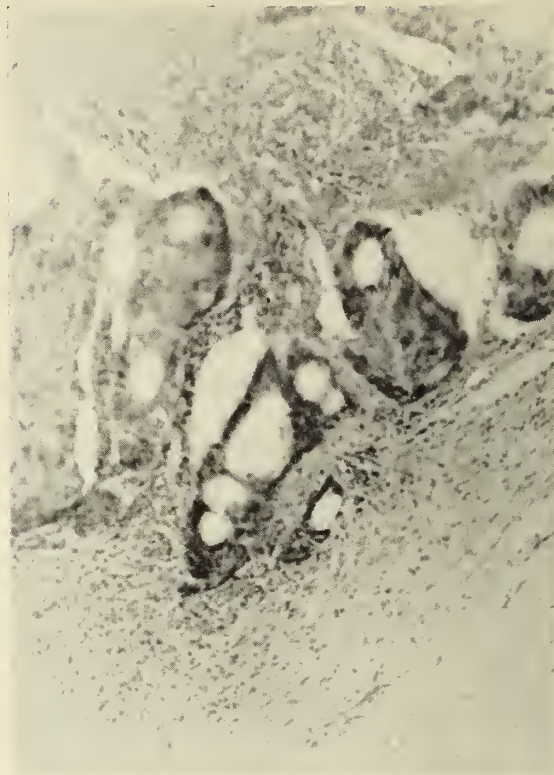
Guptill<sup>7</sup> believes all polyp-bearing mucosa must be removed, and that any segment of the rectum left with the sphincter should be sufficiently short to be readily accessible to direct vision and easy fulguration. Even this preservation of the lower rectum (within 8 cm. of the anus) may be done only when the polyps are unquestionably benign.

#### CASE HISTORY

Miss J. R. was first examined in the office in May, 1951. She complained of rectal bleeding of six years duration, and occasional attacks of diarrhea. Two months previously she had undergone a hemorrhoidectomy, at which time the operating surgeon biopsied a suspicious area which appeared to be a stricture approximately five cm. above the anal opening. The report of the tissue concluded it to be of polypoid origin with the suggestion that other biopsies be performed if possible to rule out the presence of frank adenocarcinoma.

This patient was a well-developed white female, 23 years of age, who did not appear acutely ill at the time of examination. Family history divulged the fact that three first cousins on her mother's side had died of cancer of the

FIGURE 2



**Metastatic adenocarcinoma found in enlarged para-rectal lymph node outside of stricture area. (Photomicrograph—high power)**

large bowel, and that these cousins were between 20 and 30 years of age at the time of death. General physical examination was essentially negative with no evidence of tenderness in the abdominal area and no masses palpable. Digital examination revealed a rectal stricture four to five cm. above the anal opening. A proctoscope was inserted and numerous biopsies were removed in the office. Grossly the stricture resembled one of an inflammatory nature. Microscopic sections revealed a group of hyperchromatic cells at the edge of the stricture which was suspicious of carcinomatous change, but far from definite. Additional biopsies of the strictured area failed to reveal frank adenocarcinomatous change in the lining epithelium.

The complete blood count and urine examination were within normal range, and the blood serology was negative. Complete gastrointestinal x-ray series revealed multiple polyposis involving all segments of the colon, especially abundant in the ascending portion, and the stricture in the rectum. The upper intestinal tract appeared negative for pathology.



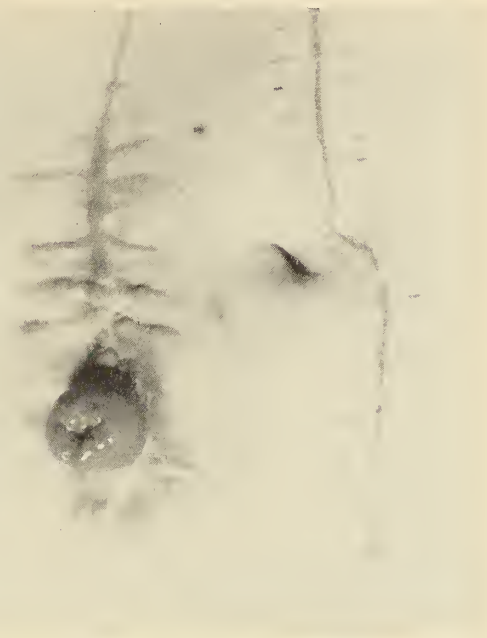
FIGURE 3



Ascending, transverse, and descending colon.

Although none of the previous biopsies had revealed frank adenocarcinoma, a radical program was planned. Following numerous cleansing enemas, low residue diet, adequate vitamin intake, and sulfathalidine preparation, an abdominoperineal resection was performed. Numerous sections were prepared from the edge of the stricture and no malignant cells could be identified. One pararectal lymph node immediately outside of the strictured area contained metastatic adenocarcinoma. There was no evidence of mucosal carcinoma in any of the numerous areas sectioned, and certainly none in any of the polyps in that vicinity. Subsequent total colectomy and permanent ileostomy failed to reveal any more evidence of malignancy. The patient had an uneventful postoperative course except for some abdominal cramps which were relieved by daily digital dilatations of the ileostomy opening. Barium studies showed an adequate ileal pouch proximal to the ileostomy opening. The patient left the hospital with no complaints following application of an ileostomy bag (Huffer type).

FIGURE 4



Ileostomy opening, and healed incisions.

#### DISCUSSION

The large majority of these patients with multiple polyposis of the colon are young. For this reason many of us surgeons "bend over backward" to spare the patient an ileac stoma (abdominal or anal), although we know that the colon and rectum should be removed to insure the patient from dying of metastatic adenocarcinoma.

At the present time it is assumed that every polyp in multiple polyposis of the colon will become malignant if that patient lives long enough.

The above case illustrates that there is a possibility of a patient developing metastatic disease when repeated multiple biopsies fail to demonstrate primary carcinoma in the mucosal wall. Does this type of carcinoma, developing from malignant change of mucosal polyps, ever metastasize "under our very noses" even though we are unable to reveal carcinomatous changes in the mucosa after repeated biopsies? We do know that some other types of malignant tumors occasionally do that very thing; malignant melanoma of the skin with distant metastasis when the primary lesion appears benign under the microscope, and nasopharyngeal squamous cell carcinoma, which oftentimes presents cervical

metastasis long before the primary lesion can be located, either grossly or microscopically.

There is the possibility that the primary lesion was missed; however, the only tissue removed from the strictured area was sectioned, and the gross specimen was carefully inspected and repeated sections made in this area.

It is difficult to agree with those who advocate "local treatment" of carcinoma of the rectum, for which one of us knows what minute of what hour of what day a primary tumor will begin to metastasize?

There remains that all-important question to answer. In the event that frank adenocarcinoma cannot be demonstrated grossly or by microscopic sections, should that patient be treated by the conservative method (subtotal colectomy and fulguration), or should he be subjected to the safer and more radical program (total colectomy, abdominoperineal resection, and permanent ileostomy)? At the present time, there appears to be a trend toward the latter.

## SUMMARY

The present-day concepts of the treatment of multiple polyposis of the colon are presented, including an interesting case history. The more radical program is suggested.

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## TWO NETWORKS TO BROADCAST DR. BAUER'S INAUGURAL ADDRESS

The presidential inaugural address of Dr. Louis H. Bauer will be broadcast nationwide on Tuesday evening, June 10, at 8 p.m. CDST. Both the ABC and Mutual networks will carry the program originating from the grand hallroom of Chicago's Palmer House during the AMA's 101st annual meeting. Consult your local newspaper for the time of broadcast in your area.



# TREATMENT OF CYSTIC ACNE VULGARIS WITH A CUTANEOUS VASOCONSTRICTOR (KUTAPRESSIN)

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THE MEDICAL LITERATURE is replete with reports on the treatment of acne in all its forms, based on the various hypotheses which have been advanced for the etiology of acne. In lieu of a solution to the etiologic complex of acne, treatment must of necessity be empirical, for relief of the dermatologic lesions and treatment of any coexistent conditions which seem to predispose to development of the lesions has been the most that could be accomplished. Topical application for peeling the skin and for correcting excessive oiliness is commonly used. The chief agents used for this purpose are sulfur, resorcin, salicylic acid, and carbon dioxide snow (cryotherapy). The latter is limited in its use because the patients object to it. Some of these methods are too strong and are irritating to the skin, hence, if used excessively may aggravate the acne rather than improve it.<sup>1</sup> X-ray treatment, which is also a peeling method, is limited because it may destroy and permanently stop activity of the sebaceous glands. Hence, it cannot be repeated in resistant cases. It should never be given to the young acne patient. Andrews obtained equally as good, if not better results when x-ray treatment was excluded from the regimen for treating acne.<sup>2</sup>

Vitamin therapy in acne has received much emphasis, and although the rationale for the use of the various vitamins is obscure and at variance among the investigators, the wisdom of improving the nutritional state of an acne patient cannot be denied. Whether vitamin D is effective because it increases the skin's resistance to secondary infection<sup>3</sup> or because it increases calcium metabolism,<sup>4</sup> it cannot be overlooked in the search for the solution to the acne problem. Vitamin A likewise furnishes a needed nutritional element. Vitamin A in massive doses, 100,000 to 200,000 units daily, is fairly standard

in the regimen for treating acne. Vitamin A in aqueous dispersion is more effective than vitamin A in oil media,<sup>5,6</sup> due to better absorption producing a higher blood level. This may be of importance in acne.<sup>6</sup>

Probably of equal importance are certain components of the vitamin B complex. Vitamin B<sub>1</sub> in maintaining normal gastric motility corrects constipation.<sup>7</sup> The B-complex provides an important achlorhydria-preventing factor.<sup>7</sup> Pyridoxine hydrochloride has been effective against acne vulgaris;<sup>8,9</sup> it was particularly helpful in drying up excessive oiliness of the skin.<sup>8</sup>

The use of estrogens in the treatment of acne is abundantly covered in the literature and to review it is beyond the scope of this paper. Very briefly, the use of estrogens in the treatment of acne is generally based on the theory that there is a disturbance in the estrogen-androgen ratio during adolescence and the menses, when the estrogen level is the lowest, causing increase in the activities of the pilosebaceous glands due to an increase in the androgen level.<sup>7,10,11</sup> In severe cases of cystic or conglobata acne, Sulzberger<sup>12</sup> gives estrogens to both men and women, as well as to women whose acne seems to be related to the menses. Female hormones, however, are given only to patients 18 years of age or over, and when the other treatment is ineffectual.

## TREATMENT

The acne problem can be managed most satisfactorily if proper treatment is begun very early and is continued until the disappearance of lesions is fairly permanent. In fact, Goldman<sup>13</sup> appeals to the family physician, who usually has contact with each child from birth through adolescence, to be on the lookout for the first appearance of comedones and to initiate early treat-

ment. I cannot emphasize too strongly the importance of early treatment, because it doubtless would eliminate or appreciably decrease the number of cystic acne cases with multiple unpleasant-looking scars and pits, which have left their mark not only on the faces of these young people, but on their personalities as well. They are conscious of their appearance, and as a consequence develop an inferiority complex which may affect them throughout life. Because of their appearance these young people are handicapped in making a place for themselves, both socially and economically. They are reluctant in their pursuit of employment, for unfortunately they are aware of their disadvantage in competing with others.

A sizeable number of these cases of cystic acne vulgaris present themselves to the author for treatment. Until last April they were placed on the usual regimen for treating acne, which included topical applications, vitamins, hormones, good skin hygiene, and avoidance of those foods which seemed to aggravate the condition. While in a very few cases it was possible to improve the acneiform lesions, the scars and pits remained, for heretofore the treatment of these and other lesions of cystic acne had been unsatisfactory.

Recently I came across the work of Marshall<sup>14</sup> in which he described a newly discovered cutaneous vasoconstricting principle obtained from liver, which was effective in shrinking the size of keloids and was apparently beneficial in treating acne. Ever since the observation was made twelve years ago, that acne vulgaris improved in patients receiving crude liver extract for blood regeneration, Marshall has studied this factor in liver which has this effect. He observed that the factor was potentiated when the liver extract was boiled, and was increased in potency with purification and concentration. He also observed that 15 minutes after administration of this material in a normal subject there was a .3 degree drop in the facial skin temperature and a blanching of the complexion. This suggested that cutaneous vasoconstriction was taking place. The preparation used by Marshall<sup>14</sup> was Kutapressin.\*

I was impressed with the results reported by Marshall, and decided to try Kutapressin in a

number of patients recently and presently under my care who were refractory to the routine methods used. I wish to report the results obtained in treating these cases.

#### REPORT OF CASES

The cases included in this report are all refractory cases of cystic acne vulgaris. They are the cases of adolescent acne which did not clear up spontaneously after adolescence, and persisted because they were untreated, were inadequately treated, or were refractory to treatment.

When treating these cases initially I employed the conventional methods enumerated earlier in this paper, namely, topical applications, estrogens, and massive doses of aqueous vitamin A in doses of 200,000 units daily. Ultraviolet irradiation was used in a few cases. X-ray therapy was used only as a last resort. At most the beneficial effect obtained from this therapy was an occasional instance of improvement in the acne. While beneficial effects were obtained from the vitamin A, it did not control the acne as did Kutapressin.

#### TREATMENT WITH KUTAPRESSIN

Twenty-two refractory cases of cystic acne vulgaris were treated with Kutapressin. The optimal regimen to follow was considered to be thrice-weekly injections of 1 cc. of Kutapressin. In some cases the frequency of injections was reduced to two weekly, although it was evident that the best results were obtained when the injections were given thrice weekly. The patients ranged in age from 13 to 27 years. Thirteen were above the age of 18. There were 15 females and 7 males. Treatment was continued for as long as necessary to obtain optimal results; some are still being treated. Two cases, one because of its severity and the other a new case, were given massive doses of Vitamin A and local therapy; two others received estrogens and massive Vitamin A; and a fifth patient was given estrogens, along with the Kutapressin injections. This constitutes the only adjunctive therapy in this series of patients receiving Kutapressin.

To date a total of 327 injections have been given to these twenty-two patients, the largest number received by any one patient being 24 injections. One patient received only two injec-

\* Kutapressin is supplied by Kremers-Urban Company, Milwaukee, Wisconsin.



tions. The majority received from 12 to 20 injections. The importance of being faithful about taking the injections was stressed; the enthusiasm which they displayed when noticing the improvement themselves or upon being told of it by their friends and family, made this fairly simple to maintain.

### RESULTS

From both objective and subjective observations, in general there was a high degree of improvement in the acneiform lesions, with noticeable regression of scars and pits, giving the skin a more smooth and normal appearance. As will be seen from the tabulations of treatment and results in Table I, all of these cases

responded to treatment with Kutapressin. With the exception of two cases, which were graded as "slight" improvement, these patients responded remarkably to the medication. Of the cases who showed "slight" improvement, one was a 14 year old girl with the follicular type of cystic acne who had not responded to the other forms of therapy when treated previously. The other case was a 26 year old girl with refractory cystic acne who was very irregular in taking the injections. In general, however, there was decided improvement in the acne after a few injections. In two cases where the cysts were so numerous as to leave practically no acne-free area, following Kutapressin many areas became free of lesions.

TABLE I  
SUMMARY OF CASES TREATED WITH KUTAPRESSIN

Case No.	Description	Diagnosis	Kutapressin Therapy	No. of Injections	Results	Previous Treatment
1	L.B. 18 yr. F	Cystic acne; high degree scarring & pitting. Multiple lesions. Very oily skin.	1 cc. 2/wk. + lotion + estrogens	19	Marked improvement. Regression of scars. Oiliness persists. Recurrence at menses.	Topical applications, and estrogens.
2	E.B. 18 yr. F	Cystic acne with much scarring and inflammation. Oily skin.	1 cc. 2/wk. + estrogens + vitamin A	11	Distinct improvement. Inflammation subsided. Looks much better.	Estrogens and vitamin A.
3	M.B. 18 yr. F	Severe cystic acne with scarring.	1 cc. 3/wk., then 1 cc. 2/wk.	24	Marked improvement. Regression of scars and pits. Appearance much better.	Treated since age 15. Ultraviolet rays, vitamin A, estrogens, local application.
4	M.D. 22 yr. F	Cystic acne; very oily skin; scarring.	1 cc. 3/wk.	14	Marked improvement.	Topical application, Salicylic acid & alcohol sponged on before lotion.
5	C.H. 22 yr. M	Cystic acne with very large cysts; scarring.	1 cc. 3/wk.	19	Remarkable improvement; scars regressed.	Vitamin A, carbon dioxide snow; local application.
6	M.J. 14 yr. F	Follicular cystic acne.	1 cc. 3/wk.	17	Slight improvement.	Topical application, estrogens, vitamin A.
7	L.K. 19 yr. M	Severe cystic acne.	1 cc. 3/wk.	16	Acne improved.	
8	J.K. 15 yr. M	Cystic acne.	1 cc. 2/wk.	2	Cysts disappeared.	Local application, vitamin A, and estrogens.
9	S.K. 26 yr. F	Cystic acne.	1 cc. irregularly	12	Slight improvement. Missed many injections.	Conventional methods—refractory.
10	G.L. 20 yr. M	Severe cystic acne.	1 cc. 3/wk.	17	Decided improvement.	Treated since 1950 with usual methods—refractory.
11	D.L. 24 yr. F	Severe cystic acne. No area free of lesions.	1 cc. 3/wk. + vitamin A + topical appl.	20	Remarkable improvement. Scarring regressed.	Usual forms of treatment—refractory.

(Continued)

TABLE 1 (Continued)

Case No.	Description	Diagnosis	Kutapressin Therapy	No. of Injections	Results	Previous Treatment
12 A.K.	18 yr. M	Cystic acne of many years duration; much scarring.	1 cc. 3/wk. + vitamin A + topical appl.	9	Improvement evident. Better appearance.	Usual forms of treatment—refractory.
13 B.R.	20 yr. F	Cystic acne with multiple scarring.	1 cc. 3/wk.	12	Regression in scarring.	Conventional forms; scarring remained.
14 M.L.S.	17 yr. F	Cystic acne of long standing; highly pigmented scars.	1 cc. 3/wk.	6	Much improvement.	Conventional forms.
15 C.T.	18 yr. F	Cystic acne.	1 cc. 3/wk. + estrogens + vitamin A	14	Noticeable improvement. Recurrence during menses.	Usual forms of treatment—refractory.
16 A.V.	28 yr. F	Cystic acne with scarring.	1 cc. 3/wk.	16	Remarkable improvement. Facial appearance better.	Vitamin A, estrogens, topical application, and ultraviolet rays.
17 G.W.	27 yr. F	Cystic acne. High degree of scarring.	1 cc. 3/wk.	6	Shows improvement.	All forms of conventional treatment—refractory.
18 J.W.	20 yr. F	Cystic acne; abundant red, violaceous scars and pits.	1 cc. 3/wk.	18	Excellent improvement. Blanching. Regression of scarring.	Usual regimen—refractory.
19 W.W.	20 yr. M	Multiple acne scars.	1 cc. 3/wk.	12	Excellent results. Scars regressed.	By usual regimen since 1949. Cysts cleared, leaving extensive scarring.
20 M.W.	13 yr. F	Cystic acne with scarring.	1 cc. 3/wk.	12	Noticeable improvement.	Vitamin A, estrogens, local application.
21 E.W.	21 yr. M	Acne conglobata.	1 cc. 3/wk.	14	Scarring regressed.	Vitamin A gave temporary improvement. Enhanced with Kutapressin.
22 N.Y.	21 yr. F	Cystic acne with scarring.	1 cc. 2/wk.	20	Remarkable improvement.	Usual regimen, including estrogens. Amenorrhea occurred for two months.

Four of these cases are sufficiently interesting to warrant more detailed discussion:

CASE 5, C. H., 22 year male, presented himself with severe cystic acne vulgaris, with many large pustular cysts. He was first treated with local applications including carbon dioxide snow, and Vitamin A, 200,000 units daily. It was necessary to incise some of the cysts with an electric needle and drain them. Since there was no improvement, this treatment was stopped and Kutapressin treatment initiated. After a few injections of Kutapressin there was a distinct improvement. He has now had 19 injections of Kutapressin, with excellent results. The infective process has subsided, scars have regressed, and the skin has a more normal appearance.

CASE 11, D. L., 24 year female, had very severe cystic acne. There was no area on her face which was free of lesions. This patient had been under my care for a long time, receiving the conventional forms of

therapy, but without apparent permanent improvement. Kutapressin injections were started May 7, 1951. Because this was such a severe case the Vitamin A and topical applications were continued as adjunctive therapy to Kutapressin. While vitamin A previously administered had improved the nutritional state, it alone did not control the acne. At the time of this report she has received 20 injections of Kutapressin, with remarkable results. There are now only 2 or 3 little eruptions remaining and the scarring is greatly improved.

CASE 18, J. W., 20 year female, had cystic acne vulgaris with abundant scarring which was violaceous in color. Initially she was treated with local applications, vitamin A in massive doses, and while some improvement in the eruptions was noted, the violaceous colored scarring remained. After she was started on Kutapressin injections, these blanched and otherwise improved in appearance. There was a general improvement in the lesions. Excellent results from Kutapressin were obtained in this case.



CASE 19, W. W., 20 year male. He had been under extensive treatment for cystic acne vulgaris since 1949. Under the conventional forms of therapy the eruptions cleared up, but extensive scarring remained. Kutapressin injections were started on June 4, 1951. He has now received 12 injections, with excellent results. Improvement which was noticeable after the first few injections is marked.

#### DISCUSSION

It has been most gratifying to note the improvement in these cases following Kutapressin injections. Since previous treatment had been sufficiently intensive and extensive to have affected improvement, there is no doubt in my mind but that the therapeutic effect in improving the acne condition in these cases can be attributed to Kutapressin. The pharmacological mechanism involved is not definitely understood. Improvement in circulation of the skin is valuable in combatting infective processes. Kutapressin may conceivably improve acne conditions by restoring normal blood flow through the skin, hence nourishing the skin and building up its resistance to invasion by micro-organisms. Marshall<sup>14</sup> believes that spontaneous excessive dilatation of the capillaries and blood vessels in certain areas, those where sebaceous glands are most numerous, may contribute greatly to the development of acne. Hemostasis which results provides a fertile field for bacterial growth. Kutapressin apparently constricts the cutaneous blood vessels, improving the blood flow in the acne lesion and decreasing the congestion of blood and tissue fluid in the papule. If pustules are present, decreasing the congestion of blood and tissue fluids in the infected area increases the resistance of the tissues in the infected area to combat the infection, and to rid itself of the infecting agent. Deep indurated cysts obviously require longer treatment.

When I first read the report of Marshall, I was in doubt about the medical rationale for Kutapressin, because I was of the impression that decrease in size and change in structure of the scars and pits in acne vulgaris could only be accomplished by surgery, but I have found empirically that Kutapressin has made this gross change in acneiform lesions, and I am, therefore, willing to accept the valuable therapeutic action of Kutapressin.

#### SUMMARY

Twenty-two cases of cystic acne vulgaris who had been refractory to the conventional types of therapy showed marked improvement when given injections of Kutapressin, a preparation containing a cutaneous vasoconstricting factor present in liver. The best results were obtained on a regimen of 1 cc. injections of Kutapressin given thrice weekly. In some cases the acneiform lesions disappeared completely, and in others they were greatly reduced in number, size and severity. The scars and pits regressed and the surface became more smooth and more normal appearing. Improvement was manifest after a few injections. No untoward effects were observed. Since all these patients had been sufficiently treated by the conventional methods without satisfactory results, they served as their own controls.

#### CONCLUSIONS

1. Kutapressin is effective in treating cystic acne vulgaris.
2. Kutapressin effects gross changes in the size and structure of the scars and pits in acne.
3. Kutapressin is well tolerated by the subcutaneous or intramuscular routes. Being used parenterally, it can be given along with topical applications.
4. While massive doses of aqueous vitamin A produced some improvement in these cases, a higher degree of improvement was possible with Kutapressin.

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#### NARCOTIC LICENSE

Physicians currently registered under the Federal Narcotic Law must file with the Collector of Internal Revenue in whose district they practice Form 678 (application for registration or re-registration), together with an inventory of the narcotic drugs on hand, copies of which inventory are attached in duplicate to Form 678, and pay the tax of \$1.00 on or before July 1, 1952. A copy of this inventory form must be kept for a period of two years.

The Bureau of Narcotics has issued a warning that official government forms, prescription pads and supplies of narcotic drugs should be securely safeguarded against theft.



# THE JOURNAL

OF THE

## INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

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## ANNUAL SESSION—1952

IT'S not too early to make plans for the 103rd Annual Session to be held in Indianapolis on October 28, 29 and 30.

Program planning is well advanced and permits an early announcement of many of the features. Opening day will be on Tuesday, and will include all the traditional events; House of Delegates, golf tournament, trap shoot, buffet supper and evening entertainment.

The delegates will meet at breakfast time in order not to conflict with the instructional courses which will open at 11:00 A.M. The instructional courses enjoyed the best attendance ever in 1951, and plans are made to repeat this performance.

Section programs will be re-established, and all six of the sections are planning for clinical meetings on Wednesday afternoon. That evening will be President's Night, with an address by J. William Wright, M.D., and a concert by the Purdue University Glee Club.

General meetings will be held on Wednesday morning, late Thursday morning and Thursday afternoon. An innovation this year is the scheduling of the House of Delegates so that neither of its sessions will coincide with any part of the scientific program.

Three of the general papers will be on hepatic disease. Hepatitis, cirrhosis and surgical jaundice will be discussed, and the formal presentations will be followed by a panel discussion, to be moderated by J. O. Ritchey, M.D.

"Treatment of Shock in Major Disaster without Blood or Plasma" and "Problems and Dangers of Transfusion" will be presented by guest essayists in another symposium of special interest in relation to Civil Defense planning.

"Chemotherapy in Tuberculosis" and "Human Infertility" will be discussed in another part of the program.

A more detailed program will be published later. Meanwhile, it's not too early to make plans to be in Indianapolis, October 28-30.

## COMMISSION ON FINANCING OF HOSPITAL CARE

A COMMISSION was organized late in 1951 for the purpose of studying the problems involved in the financing of hospital care. The project was initiated by the American Hospital Association. However, widespread interest on the part of other organizations and many individuals was discovered, and the commission is now functioning as an independent agency.

Its membership is composed of 34 individuals who represent, as nearly as possible, all the agencies concerned with furnishing hospital care, as well as all large groups interested in the purchase of hospital care. The chairman of the group is Gordon Gray, president of the University of North Carolina.

After preliminary investigation the commission has decided to devote a major portion of its budget and staff resources to intensive study of the following basic problems:

1. Evaluation of the current financial position of hospitals and a determination of hospital cost elements and the factors that affect these elements, including identification of cost and methods of financing medical research and professional education;
2. Physician-hospital relationships and varying patterns of medical practice as they affect the cost of hospital care;
3. Financing of hospital care for the non-wage, low income, rural and chronic illness groups;
4. Problems associated with voluntary prepayment of hospital care, including methods for determining amounts of payments to hospitals by prepayment and other agencies buying care.

Certain selected communities and one entire state will be the subject of special surveys which will be conducted so as to encompass all the major problems under study. Advisory committees and various experts will aid in the collection and study of data. All research which has been completed in this field will be reviewed so that the commission activities will not duplicate or overlap the work of other agencies.

Inflation and other factors have raised the cost of hospital care at a time when the demand for hospitalization has increased tremendously.

The present shortage of hospital beds has further complicated the problem.

Now is certainly the time to solve these problems on a basis of adequate information. A factual and unprejudiced study of the entire situation is indicated, and should provide a solid foundation upon which to build a rational solution.

## NURSING PLANS TO REORGANIZE

BEFORE next fall nursing expects to have a new national organizational structure. Instead of the six national organizations that are now concerned with professional nursing, there probably will be only two. These will be the American Nurses' Association and the National League for Nursing.

In 1950 all six groups voted to realign into two organizations. They asked national committees to work out the details of a plan so that it would be ready for action by the members during the summer of 1952. It was understood that one of the organizations would be the American Nurses' Association and that it would continue to be an all-professional nurse organization, exclusively for professional nurses. The other was to be a new organization for all those interested in improving nursing services and education—nurses and non-nurses alike.

In the new two-organization plan, the American Nurses' Association will promote the professional, general and economic welfare of professional nurses and help them become the best possible practitioners as individuals and as members of a profession.

"National League for Nursing" is the name being proposed for the new national nursing organization. When the members take necessary action, it will replace and carry forward the major programs of four of the present groups: the American Association of Industrial Nurses, The Association of Collegiate Schools of Nursing, the National League of Nursing Education, and the National Organization for Public Health Nursing. In addition the NLN will assume responsibility for activities in nursing never before developed.

The NLN will be unique among membership organizations in the United States—and, so far



as is known—anywhere in the world. Through the NLN it will be possible for nurses who give direct care to patients, as well as other nurses, administrators, board members, allied professional workers such as physicians, and consumers to work together to develop and improve organized nursing services in communities. Through the NLN it will also be possible for nurses in all occupational fields and positions, teachers, other educators, administrators, and consumers to work together to improve educa-

tion for nursing, so that nurses will be prepared to give the kind of service the people need.

Realignment of the national nursing organizations will make it possible for nursing to achieve close coordination of effort and at the same time preserve the diversity which stimulates the growth of various phases of nursing. Through a two-organization structure nurses, members of allied professional groups, and other citizens will be able to work together more effectively toward a common goal.

## *Letters to the Editor*

Editor of THE JOURNAL:

For about three weeks in March, and then every Friday morning since that time I have been doing some extra work in anesthesia at the University Hospitals, under the direction of Drs. Stoelting and Graf and the resident staff. It occurred to me that the opportunity for practicing physicians to do this type of postgraduate study should be publicized in our state JOURNAL.

The best postgraduate work is that where the doctor can see and do the work himself. While the University Medical School may not have the facilities to accommodate many physicians at one time, I am sure they would welcome the opportunity to be of service whenever possible.

Everyone connected with the surgery, nursing, and anesthetic department have been most helpful, and the opportunity to associate with the younger men has been of inestimable value to me. Perhaps in years to come an expansion of the physical plant would permit more practicing physicians to make use of this type of postgraduate work.

Walter L. Portteus, M.D.,  
*Franklin.*

Dear Dr. Ramsey:

A patron of the Society for the Prevention of Asphyxial Death Inc., interested in making the causes and prevention of asphyxial death better known among physicians of Indiana State, has

kindly offered to donate a copy of the *Art of Resuscitation*, by Paluel J. Flagg, M.D., to the first 100 Physicians who become members of the Society following the release of this information in *The Journal of the Indiana State Medical Association*.

Reviews are enclosed. You may wish to quote one or more.\* The book lists for \$6.00. Volumes donated will be autographed by Dr. Flagg.

Physicians who wish to receive this autographed volume for their library are asked to apply for membership in the Society for the Prevention of Asphyxial Death, Inc., enclosing membership dues of \$5.00. Communications should be addressed to, Secretary, S.P.A.D., Inc., 2 East 63 Street, N. Y. 21, New York.

Dr. Chevalier Jackson in the preface of this book says, "To learn from this book means to save human lives."

May we ask your cooperation in publicizing the offer of our patron to the end that Dr. Jackson's belief may become more completely realized in the state of Indiana.

Very sincerely yours,  
J. Richardson, Secretary.

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\* "The author has succeeded in his attempt to present the reader with a *clear, precise, and complete* picture of the asphyxia patient. The reader's first impression is how could a writer condense under one cover such a *vast amount of information* and still have a book that is *so easy to read*."



## President's Page



ON APRIL 24 I had the pleasure of attending the annual dinner of the House of Delegates of the Woman's Auxiliary of the Indiana State Medical Association.

It was my privilege on that occasion to introduce Dr. John W. Cline, president of the American Medical Association. Doctor Cline, as usual, delivered a most impressive message, which might well have been enjoyed by the entire membership of the state association.

It was a treat to be one of about a half dozen men to look on the gathering of women delegates who presented a beautiful array of gowns and hairdos, in addition to a most masterful display of management, from cocktails to adjournment.

The women are to be congratulated on their accomplishments, for no doubt their activities have been a tremendous factor in the fight against socialized medicine.

There are a few communities where the women are not as well organized as in others, and I would like to add a few words of encouragement for an extended drive for more members. Local and district medical societies will find many situations where the auxiliary will contribute to the success of efforts in which they are interested. It will do much toward getting a community medically conscious and medically minded. The membership now is 2,205.

The auxiliary has been active in nurse recruitment work, which is a very vital part of medical care. They have had teas and tours of hospitals to acquaint high school girls with the opportunities available in the nursing profession. Approximately 30 nursing scholarships have been given by the auxiliaries.

This year the auxiliary assisted the Rural Health Committee by conducting two regional rural health meetings for women. The first was held March 27 at Lancaster Township School in Wells County, and had an attendance of 525. The second conference was held at Indiana University on May 21. Subjects discussed at these meetings were nutrition, cancer, heart, and mental hygiene.

On behalf of the state medical association, and personally, I congratulate the Woman's Auxiliary for its magnificent accomplishments, and sincerely trust that the organization shall continue to grow.

*William Wright*



## Dear Doctor:

We believe every doctor wants to help. But! ! !

Are you one of the 600 loyal Hoosier physicians who have to date pledged \$51,000 in our campaign for Medical Education Foundation?

Or do you belong to the group of nearly 3200 members who have given nothing?

Our Medical schools need our financial help—Now! ! ! Donations are tax exempt and you can choose the school you desire to aid.

Think it over and decide to which of the above groups you want to belong. If you have contributed in 1951, we ask that you repeat or increase your pledge for 1952.

The names of all contributors will appear in the July issue of our state JOURNAL.

**Fill out the pledge below and mail it now!!!**

### PLEDGE CARD

Indiana State Medical Association, Medical Education Fund.

I hereby subscribe ..... DOLLARS per year for a period of (1) (2) (3) years to the American Medical Education Foundation as my contribution to assist our medical schools.

Please bill me

( ) Semi-annually

( ) Annually

( ) Check in full enclosed.

I understand this money will be turned over to the American Medical Education Foundation, with the understanding that my contribution will be given to the following medical school.....

Name ..... M.D.

Address .....

(Make your check payable, Indiana State Medical Education Foundation Fund,  
1021 Hume Mansur Building, Indianapolis 4, Indiana)

# Medical Panorama

by the  
ASSOCIATE EDITOR

## IF THE SHOE FITS

An editorial in the *Detroit Medical News*, February 25, 1952, by John H. Schlemer, M.D., calls attention to some very old truths which can easily be neglected or passed by in the rush and drive of medical practice. Since the shoe fits us all too many times, we thought you might be interested in trying it on—for size. Here 'tis:

### JOE THE MAN

For twenty-eight years now I have been listening to the ever occurring complaints that doctors are coldly aloof, too busy to have the human touch. Joe Dokes and the Missus both seem to feel that their doctor—and that goes for nearly all of us—is interested only in the symptoms that they present. We know for a fact that the coldness is an exterior shell that hides a kindly heart. But this kindness will do Joe no good if he doesn't know it's there.

Joe is an average man. He works every day and sleeps and eats, and listens to the ball games, and loves his wife and kids. He doesn't make much money, but who does? He pays his mortgage and taxes and doctor bills. And he carries insurance for the sudden emergencies that might spell disaster in the average home. He is your patient and mine. And maybe we haven't done so well by Joe.

We talk a lot about public relations and hire an expensive staff to tell the public what good guys we are. But in our personal contacts with Joe, we sometimes meet him with face as devoid of expression as a

cigar store Indian. In the office he finds himself passed along from office assistant to doctor and back to assistant and out the other door, with never a moment to pass the time of day. On that once-in-a-lifetime stretch that Joe serves in a hospital bed, he looks for his doctor's visit as a shining spot in a weary day. But the doctor is busy again. He sails into the room and out again with only a "How do you feel?" the answer to which he doesn't appear to hear. And Joe's stomach curls up in a hard knot of fear—fear of the unknown, of the answer to the question he dared not ask. For all Joe knows, the doctor didn't see him at all. He just looked right through Joe to the gall bladder that had given such terrific pain. It wouldn't have taken much time to show Joe what it was all about. A few moments of explanation, a reassurance that all was well, and we'd have had a happy patient in place of a fearful one. It's a simple thing, but the therapy is good. And it saves our public relations from going sour.

Joe is only human like the rest of us. We all respond to kindness like so many friendly pups. And the rewards are rich, not in dollars and cents, perhaps, but in healthier public relations and patient morale, in an added confidence in the doctor and his skill that springs from Joe's understanding of what is being done. And let us not forget the psychological income that derives from sympathetic contacts with our fellow men. For, after our lives are spent, and the Old Grim Reaper has gathered us in, it isn't going to matter so much that we knew all about that gall bladder of Joe's. The one that counts on the other side—and the one who really counts right here—is Joe the man.





# The Fourth Estate Looks At Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

## FARMERS STUDY DOCTOR SUPPLY

The number of physicians in Elkhart County has increased from 72 in 1945 to 89 this year, according to the public relations committee of Elkhart County Medical Association.

This, admittedly, is not the whole story as to the doctor supply, in general.

But we mention the figures to introduce an article in February's "The Hoosier Farmer," publication of the Indiana Farm Bureau.

"Training of doctors has not kept pace with the population increase," says the story's caption.

The writer goes on to say that the number of "general practitioners" is declining, and that rural areas of Indiana especially are feeling this pinch. Some communities of 1,100 persons are without a doctor.

"We do not primarily oppose the fees doctors receive," says the writer. "The point we are trying to make is that there would still be plenty of doctors for rural and urban people if the medical schools would admit a greater number of applicants."

To back this up, the writer says that last year, of 906 applicants to the Indiana University School of Medicine, only 150 were accepted.

This article has interest for a particular reason. The Farm Bureau is not one of the "left-wing" groups. The Farm Bureau is waging its own fight against "big government." Yet the arguments about the doctor shortage are identical with those put out by the Fair Dealers.

Most folks we know—even including some doctors—think we should have more physicians.

But here's where we differ among ourselves:

1. Just how many more we need and can afford?
2. Who will pay for the extra trainees—government, or private groups?
3. In exchange for large subsidies, should doctors bind themselves to serve a time in a low-income community?

The Indiana State Medical Society finances a

few scholarships, and makes some effort to place physicians in counties now lacking them.

Perhaps more could be done along this line. Perhaps other private organizations might finance similar grants.

Because medical education is an increasingly expensive and lengthy proposition. If "someone" doesn't help, the government will be asked to do so, and in effect this will mean more doctors working for the government.

The Farm Bureau article also hints at the idea of lowering medical school scholastic standards. We're skeptical of this general idea.

What we can imagine, however, is that a better job of distribution could be done. And here, individual communities can take an initiative.

For instance, Elkhart county has 17 more doctors than it had six years ago. Yet there is a "centralization" trend. A number of rural neighborhoods have fewer doctors than before, while the cities gain.

A spokesman for our County Medical Society says this can be remedied if communities will actively seek a doctor. He says he has had several inquiries from I.U. students about Elkhart County. And the two questions most asked are: Is there a house I can live in? And, is there office space?

Perhaps doctors, like customers, "go where they are invited, and stay where they are well treated."

There is another reason for the crowded waiting rooms, we think.

The purchasing power is greater than it was 10 years ago. More of us are in a position to seek more care.

All this is aside from other questions, such as financing of "catastrophic" illnesses that even middle income groups can't afford. Extension of voluntary pre-payment plans to such coverage is afforded as one solution to this.

But as to the doctor supply itself, it would seem there is much that medical groups and individual communities, working together, could do to relieve shortages where they are felt most keenly.

—The Elkhart Truth

## MY FIFTY YEARS OF PSYCHIATRY\*

MAX A. BAHR, M.D.

*Indianapolis*

**I**N OFFERING this presentation it is my aim to give a picture of my personal experiences of more than half a century's affiliation with Central State Hospital. It is not my endeavor to present an exhaustive survey of the scientific field throughout this period as conducted at the Central State Hospital but a much more intimate one from a personal and general viewpoint.

I wish to show what has happened in these more than fifty years as I have seen it, for during this time all the great developments in the field of psychiatry have taken place and I have seen them unfold before my eyes; and in many instances the Central State Hospital has taken an active part in the scientific progress in psychiatry during this period.

In this relatively short span of time practically everything that is of outstanding importance and significance has in reality occurred. While the humanitarian era is arbitrarily thought of as having been ushered in in America by Dorothea Dix in the last of the eighteenth century, still fifty years ago there were conditions in some state institutions that were quite as atrocious as those which Dorothea Dix undertook to correct in America.

What I am trying to portray in this presentation is to tract not chronologically but functionally the changes that have occurred from this medieval period in our social organization to the advanced positions of the scientific salient of the present day, and which have occurred during the period of my lifetime.

It is of course unfortunately true that many primitive conditions still exist, and it is also true that no one who is forward-thinking is satisfied with what has been accomplished. In other words, there are still evils to correct and progress is still taking place. From the hideous conditions of medievalism to the best conditions found in our modern hospitals is a gigantic stride and involves radical changes of thought,

feeling and attitude, and improvement in methods, together with the utilization of facts which have been disclosed as a result of the advance of science.

The things which have been happening to psychiatry in the past fifty years are the beginning stages of what may be perhaps the most significant thing that has ever happened to man in the course of his life on earth. They are the beginnings of man, his first efforts to come to grips with himself, to face the realities of his instinctive drives as they lie buried beneath the disguises that modern civilization demands.

During my period of experience in psychiatry I desire to emphasize four phases in its evolutionary development, which represent the greatest progress in this particular field of medicine. These are our better understanding of the causes, interpretation and treatment of mental ill health; the prevention of mental illness; the promotion of positive good mental health; and the emergence of the historic isolation of mental illness and its close relationship to other fields of medicine and research.

We institutional physicians in our state hospitals accumulated an experience with the behavior of insane individuals which gave us an understanding of why these people acted queer, which opened up an entirely new field in the science of the human mind. We discovered that there were general laws governing behavior, laws as definite as those governing breathing or digestion. We observed the ways in which these laws might be used to rehabilitate some of the wrecks. After this knowledge became available psychiatry then came into its own and finally became recognized as a medical specialty.

Thus psychiatry became acknowledged by the medical profession as a topic of systematic investigation and teaching on an equal footing with the diseases with which general medicine dealt. At the time of my entrance into this field of medicine, psychiatry was largely limited to state institutions. In the following years it

\*Delivered on the occasion of the Farewell Testimonial on January 10, 1952.



formulated principles which made it applicable in the everyday life of every individual. Thus the application of these principles to all types of social situations, as industry, education, recreation, child guidance, criminology, and also religion.

The problems were first carried out under the domination of the pathological anatomy, and the first laboratory connected with a state mental hospital in America was erected at the Central State Hospital. This laboratory has a remarkable record of advance in the knowledge of the mental illnesses which are due to physical causes. It made the institution nationally prominent and added to the medical prestige of Indianapolis. If its work will be permitted to continue after my retirement, I should consider it the finest memorial to my name.

Upon my entering the field of psychiatry the old ideas of mental illness, which had dominated so long, were still in existence as they were elsewhere throughout the country. Patients were either maniacal, melancholic or demented.

Paresis was occasionally diagnosed but there was no more than a suspicion that there was any connection between it and syphilis, and the mental examinations consisted of undirected conversations with the patient, followed by brief notes written in ponderous case books by long-hand. There was very little if any suggestion that the mental symptoms had any meaning back of them, that the psychosis was a reaction of the organism in any way, defensive, compensatory or otherwise.

The whole situation was looked upon as being pretty much a mystery and there was hardly any light to be had on these questions from any source. Finally an evolution and development in this branch manifested itself when its intricate problems were attacked from the viewpoint of science.

Consequently when attacked from this angle, mental disease began to become understood. It was appreciated that mental illness resulted from certain stresses applied to a certain personality make-up and in which the symptoms then appeared as the result of the stress acting upon this make-up, and expressed in symbolic form the way in which the personality, more particularly at its weak points, strives to meet the situation.

Psychiatry then assumed the attitude, not with the study of a longitudinal section of the disease process, its course and outcome, but with a longitudinal section of the individual which shows how a given type of personality make-up has reacted to a given type of stress and how it has brought its assets and liabilities to the problem in hand, how it deals with this problem, and how finally it is solved.

Probably one of the greatest advanced steps in the evolutionary development of psychiatry in the past two decades was the interweaving of psychiatry with internal medicine. Physicians have always known that the emotional life had something to do with illness but they separated illness from the psyche of man and considered disease as only a disorder of organs and cells. The psychological background of the patient was not taken into consideration. The feeling existed that the physical findings were sufficient to account for the illness. In disease we must study the individual as a whole; a real understanding of psychopathology is necessary in order to study the emotional life in relation to ill health. This present surge of interest has brought psychiatry into closer rapport with general medicine.

Long before the relationship between mind and body was recognized, psychiatry had taught that man was a total and indivisible unit, and therefore, in health and disease, every physical ailment reverberated in all of the man and particularly in his emotions; also, conversely, that every emotional reaction had repercussions in every cell and tissue of the body.

Studies with such topics as the effects of emotion on the stomach or on the heart will tend to reorient us a little away from emphasizing the individual as a whole, to some regard for its parts and some understanding of the physical mechanisms set in operation. This reaction has placed new emphasis on the relationship of mind and body and their mutual reactions in disease processes. Prolonged emotional disturbances are recognized as potent causative agents, as bacteria are recognized in the production of certain organic diseases. In so far as the broad aim of medicine is to prevent and relieve suffering, psychogenic illnesses deserve their share of consideration by the physician.

During my period of service in psychiatry there have been new forms of treatment devised

for the mentally ill. Outstanding was the introduction of the malaria treatment in paresis which until recently was indispensable in treatment of syphilis of the nervous system. Also the use of sodium amytal to produce prolonged sleep, and the more recent and amazing shock methods of treatment of certain types of mental illness with insulin, metrazol and electric therapy.

In the past fifty years the science of psychiatry has been progressing steadily until today mental disease has been put on an equal footing with other forms of illness, and now receives the same intensive study and skillful nursing as does any other problem in general medicine.

In the past few years prefrontal lobotomy in the treatment of certain types of mental cases has caused increasing attention, in which this type of modern brain surgery has become a reality. Up to this time practically all the studies are inadequate because there has been too little stress laid on the investigation of the possible deteriorating effects of such a therapy on the personality of the individual.

Psychotherapy has come very much into prominence in recent years. Its aim is at accomplishing the overcoming resistance and the transference of the patient's energy from harmful to useful forms. There are many methods of techniques available, and include any legitimate psychotherapeutic measures which influence favorably the attitude of the patient towards himself, his illness and his environment in life. Psychotherapy endeavors to teach the patient the nature and causes of his illness, the mechanisms through which the symptoms are produced, and how and why they continue to operate.

The Central State Hospital has been one of the pioneers in malaria therapy in paresis in America, and its various lines of research in this particular endeavor have gained widespread recognition, not only on this continent, but also abroad. State and private institutions, general hospitals, practicing physicians of the state of Indiana and also throughout the Middle West have made use of the opportunity offered by us, and brought their patients to the hospital for malaria inoculation or had malaria blood shipped to them by mail. Through this service the Central State Hospital was practicing mental hygiene, which is at once obvious, and constituted an

immediate saving to the state, as such patients never became institutionalized later.

In 1932 I outlined a program for a Diagnostic Clinic and a properly staffed outpatient clinic, which is as essential as adequate hospital care and treatment in a well-balanced mental health program, since such clinics serve three principal and necessary functions. This recommendation did not meet with approval at that time but will now be carried out in completion of the screening hospital located at the Indiana University School of Medicine. The three important needs which will be met by this service are that hospitalization of cases can be postponed or prevented; will make possible the earlier discharges in many cases; and also the function of public education.

The clinic develops in the community an awareness of the need for early diagnosis and treatment, and a better and more rational understanding of mental disease and mental health, which is one of the objectives of any public health program.

In the past half a century psychiatry has become a specialty in medicine and is setting its standards ever higher and higher, not only in the care of the mentally ill in the hospital, but in the application of psychiatry to community problems and problems of general medicine. Psychiatry has presented in its development the results attained by man in his efforts to understand himself, and bids fair for sometime to come to present in its results some of the most important and significant additions to scientific knowledge.

I entered the service of the Central State Hospital in 1898 after having served as chief resident physician of the Government Emergency Hospital in Washington, D.C. There I had the opportunity of frequently visiting the St. Elizabeth Hospital, which is the Government Hospital for mental cases. It was there I absorbed a great deal of enthusiasm for psychiatry and appreciated the great possibilities in this particular field of medicine. The influences to which I was exposed there were represented in a fixed direction that never ceased.

I first entered the Central State Hospital as assistant physician, later was promoted to clinical psychiatrist, and eventually to superintendent in 1923. On entering this institution I



soon realized that American psychiatry was far behind that of the Germans, and upon request was granted an extended leave of absence, when I had the privilege and good fortune of being under the tutelage of one of the foremost psychiatrists in Europe at the Charity Hospital in Berlin, Germany.

It was upon my return to the Central State Hospital that the psychoanalytical movement began to manifest itself. It was during this era that mental problems were tackled, in that some meaning was discovered in the symptoms of the psychoses, and it has given these symptoms a meaning, and consequently the psychoanalytical movement made a great contribution to the understanding of mental illness. My understanding of this situation became very convincing, and as president of the Indianapolis Medical Society in 1932 I presented an address entitled "Psychological Factors in Medicine," which at that time was received with skepticism, but which today is the basis of psychosomatic medicine which gives us an understanding of many of the forms of physical illness.

The relationship between crime and mental illness has always been of great interest to me and the first clinical course in forensic psychiatry for attorneys in America was given at the Central State Hospital, in consequence of which I was elected an honorary member of the Medico-Legal Society of New York City.

I am a member of all the nationally recognized neuropsychiatric associations and for a number of years was head of the department of psychiatry at the Indiana Medical Center in a teaching capacity.

In severing my connection with the Central State Hospital, I want to take this opportunity of expressing my sincere gratitude to the various individuals who were associated with me from time to time throughout the tenure of my service, the various trustees and colleagues, with their wonderful cooperation rendered me at all times. It has been their confidence in me and helpful guidance which has made the performance of my duties one of the greatest

pleasures of my life. The family physicians of our patients have aided me in the solution of many of our problems, for throughout all ages the spirit of the family doctor has been one of the great moving forces in the development of our civilization and culture.

The medical profession is cemented by a code of ethics which represents the highest ideals of American citizenship, of honor; it has fostered upon us the Golden Rule; all of which points the way to a better citizenship and to a broader and better world. It represents the guiding spirit of mankind in a struggle to ameliorate much of the suffering and misery which man encounters in this life. To the sick we give help, to the bereft we bring solace. We comfort the hearts of those upon whom disease and the mist of sadness rests like the fogs upon the mountain peaks, and lift these burdens by our skill and touch of human sympathy.

My greatest experience in the past half a century has been in the realization that in living our lives we must do so with a definite purpose in view. A life without a purpose is a very dull life indeed. We all know from personal experience how tired we may become while doing nothing, but let us once find an outlet for our energies, some object upon which to expend them, and our instinctive powers awaken us to life. The Sea of Galilee is fresh and blue, and gives life to living creatures within its sunlit waters, not because it receives waters, but because it gives of them freely. The Dead Sea is dead, not because there is no supply of fresh water, but because it permits no outlet. It is therefore stagnant and deadly; no fish lives in its waters, nor is any beast to be found upon its shores. It is a law of nature, a law of life, that only by giving shall we receive. None is so healthy and fresh as he who gives of his strength and talents and thereby liberates his impulses and instinctive powers into quickened activity.

Whatever the future may have in store for us in the way of brilliant discoveries, our present efforts to restore suffering man to health and happiness and to return him to his family and friends will ever hold a high place of honor in the storehouse of human endeavors.

# RULES AND REGULATIONS GOVERNING THE PROCEDURES AND OFFICIAL ACTIONS OF THE BOARD OF APPEALS ON PATIENT-PHYSICIAN RELATIONS

As approved by the Council of the Indiana State Medical Association  
April 26, 1952

## 1. PURPOSES of the BOARD

1-a. To be the official body of the Association to receive, consider and investigate complaints and reports concerning professional conduct and ethical deportment; and to act as the Association's official agency in conducting investigations and securing evidence in cases that may need disciplinary action, or corrective measures for better public relations.

1-b. To discourage and abate unethical practices that jeopardize public respect and confidence in the medical profession.

1-c. To act as a liaison committee to aid and encourage the physician and complainant patient in getting together and amicably settling any dissatisfaction or complaint growing out of misunderstanding or due to lack of information on the pertinent facts involved.

1-d. To protect and defend the physician and the medical profession from unjust criticism resulting from misunderstanding, misstatement of facts or malicious falsehood and slander.

1-e. To prepare for issuance to the entire membership in bulletin form through the executive office or in *THE JOURNAL*, periodic bulletins on ethical deportment and containing educational examples of good and bad public relationship for the physician.

1-f. To prepare for issuance through the public press, periodic announcements and news items informing the public of the presence, purposes and functioning of the Board of Appeals on Patient-Physician Relations of the Indiana State Medical Association and that the medical profession welcomes constructive criticism and is interested in hearing and adjusting grievances that the lay public may have against individual physicians or the profession.

1-g. To secure evidence and prepare charges for filing against any physician deemed by the Board guilty of unprofessional conduct. These charges may, in the discretion and judgment of the Board, and in accordance with these rules, regulations and authority, be prepared for filing originally with the Censors or Grievance Committee of a component County Medical Society or direct with the Council of the Indiana State Medical Association. Charges to be filed with the Indiana State Board of Medical Registration and Examination or with any criminal court must be first approved by the Council of the Association.

1-h. By way of further definition, it should be understood that the Board has no final jurisdiction in a judicial way. It will receive and pass its own judgment upon evidence, but it will not assume authority to discipline any physician. It may at any time express its advice or recommendations to a member of the Association or to a component county society on any matter pertaining to professional conduct.

1-i. In pursuance of its function within the structure of the Association, the Board shall have the power and authority to summon members of the Association to appear before it, either in connection with complaints involving the members summoned or as witnesses in cases involving other members. In case any member shall fail to respond to such summons, the Board of Appeals shall cite the member before the Council for contempt proceedings.

1-j. It shall not be the purpose or function of the Board to establish fee schedules for medical services. However, it is the duty of the Board to investigate complaints regarding bills rendered by a physician in a specific case. This shall be done in order to protect the interests of both physician and patient.

## 2. STANDARDS of CONDUCT

2-a. The current edition of the "Principles of Medical Ethics of the American Medical Association," and the Constitution and By-Laws of our State Association as interpreted from time to time by the Council of the Indiana State Medical Association shall be the final standard by which all professional conduct and ethical deportment are determined.

## 3. ORGANIZATION of BOARD

3-a. The Board annually elects a chairman, a vice-chairman, and a secretary from among its own members. No member of the Board may participate in the deliberation of questions concerning the conduct of a physician residing in the jurisdiction of that Board member's county society. In view of this fact the vice-chairman will preside in all cases involving a member of the chairman's county and the vice-chairman will serve as secretary in all cases involving a member of the secretary's county. Thus, two disinterested officers of the Board will always assume these functions. Any person against whom an accusation is made will



be informed that the member of the Board residing in his county will not be present during the Board's deliberation of that case.

3-b. If a complaint is filed against a member of the Board, the member shall retire from the Board meeting while his case is being considered and the complaint shall be handled the same as any other case.

3-c. If a complaint is filed regarding any action of the Board itself, the Council shall have sole charge of the investigation.

#### 4. PROFESSIONAL and TECHNICAL ASSISTANCE

4-a. No person other than appointed members of the Board, Executive Secretary, official attorney and stenographer, and any witness then being heard will be admitted to any part of the proceedings of the Board except upon official summons of the Board.

4-b. Should it become necessary in the opinion of the Board to take testimony in any case, the Board will obtain the service of a competent shorthand reporter:

4-c. In the event the Board reaches the point in any investigation where the Board feels that charges should be filed and prosecuted against a physician, the Board should, before making recommendation to the Council regarding the filing of such charges, consult with the regular retained attorney of the State Association to determine the sufficiency of the evidence and for him to prepare the necessary papers.

#### 5. RULES and METHOD of PROCEDURE

**Complaints to Be Considered** 5-a. The Board will receive complaints in writing from any person, whether or not he or she be a physician, a member of the society, an employee of the society, a patient of a physician, or any other person, lay or professional.

The Board will also receive complaints or constructive criticism or recommendations for improved medical care from any person requesting in writing an appointment to appear before an official meeting of the Board and willing to have his or her statements included in the official records of the Board. All written complaints and written requests for a hearing by the Board should be addressed to the Board of Appeals on Patient-Physician Relations, Indiana State Medical Association, and marked "Confidential."

No anonymous or fictitiously signed written complaints and no verbal complaints received by individual members of the Board, or by the Association officers or employees, will be considered by the Board.

The Board of Appeals will not consider complaints

on medical services rendered more than *one* year before the complaint is received by the Board, except in cases that may involve slander or injury to a physician's reputation, or charges of gross immorality and unprofessional conduct or criminal malpractice.

5-b. The Board will respect the confidential nature of any complaint, provided that any complainant, physician, or other person involved who is unwilling to appear personally before the Board when requested will be given to understand that such unwillingness prejudices against the possibility of the Board being able to make a complete investigation. Furthermore, the complainant must recognize that a copy of the complaint must be sent to the physician against whom the complaint is made in order that he or she be able to cooperate in the investigation.

**Prerogative of The Physician** 5-c. In every complaint received by the Board, the physician and the patient will first be given an opportunity to adjust their differences without further official action by the Board.

The Executive Secretary of the Association shall send a copy of the complaint to the doctor against whom it is lodged, over the signatures of all members of the Board, and the doctor shall submit a statement of his side of the case, either in writing or by personal appearance before the Board within the time specified by the Board. The accompanying letter shall ask the doctor to contact the complainant and endeavor to amicably adjust the complaint.

The Executive Secretary of the Association will acknowledge receipt in writing of all complaints and will inform each complainant that a copy of his or her complaint will be brought to the attention of the physician against whom it is lodged and that it is the hope of the Board that an amicable and satisfactory adjustment or clarification of the complaint can be made. Acknowledgement of receipt of this letter will be requested in order to determine that the name and address of the complainant is authentic.

If the physician and the complainant come to a satisfactory agreement without further action by the Board, the Board will close the case and will so notify the complainant and physician and thank them for their commendable action.

**Prerogative of The County Society** 5-d. Complaints received by the Board of Appeals and not amicably settled by the physician and the complainant within the specified time or to the satisfaction of the Board, shall then be tendered to the defendant physician's county medical society for local adjustment, investigation or disciplinary action. However, the complaint shall remain on the docket of the Board until the Board officially decides that fair and ethical consideration has been given to the complaint and proper action taken. The Board of Appeals shall then notify the

component county society, the defendant physician and the complainant that the case is closed.

It shall be the duty of any component county medical society to accept or reject in writing any complaint referred to it by the Board of Appeals. Any county society failing to act or report action taken in a specific case referred to it by the Board within the time fixed by the Board shall forfeit the jurisdiction offered and the Board will proceed with the investigation.

Upon the written request of a County Medical Society, the Board at its own discretion and judgment may grant an extension of the time fixed for the county society's report of action in a specific case. The Board shall not permit prolonged delay or inaction by a county society in any case referred to it and at the expiration of the fixed time or extended time for report of a case, the Board shall notify the County Medical Society that their jurisdiction in the case is terminated. The Board shall then proceed with the investigation of the original complaint.

The Board of Appeals shall have no jurisdiction and shall not take action in any complaint filed by a complainant directly and solely with a local county medical society, except when the society requests in writing that the Board handle the case.

In complaints filed both with a county medical society and with the State Board of Appeals, the Board shall retain the right of jurisdiction until the case is terminated, but the county medical society shall be offered the priority right of handling the case as provided in these printed rules, regulations and procedures.

In complaints filed only with a county medical society or referred to the society by the Board of Appeals the action, decision or recommendation of the county society may be appealed or referred to the State Board of Appeals on Patient-Physician Relations by either the defendant or complainant, physician or patient, or by the county medical society itself. In these cases appealed to the Board, the Board shall review the evidence and actions of the County Society and summons the defendant and complainant to appear before the Board if they wish to present further testimony in the case appealed.

In complaints involving (1) two or more physicians who are members of different county medical societies, (2) a complainant who resides in one county and a physician or physicians who reside in another county, (3) professional services rendered in one county by a physician or physicians who reside in another county, each county society involved directly or indirectly shall be tendered the prerogatives and privileges provided herein and may make separate or joint investigations.

5-e. The Executive Secretary will likewise, in consultation with the chairman, arrange for meetings

of the Board with such frequency as may be necessary so that investigation of each complaint is carried out with reasonable dispatch, and will notify complainants and any other persons whom the Board wishes to interview concerning meeting dates and places. The Executive Secretary will, at all times, keep the chairman informed concerning the progress of investigations conducted otherwise than at meetings of the Board. Copies of all new complaints received are to be mailed to each member of the Board prior to or with the call for the next meeting of the Board.

5-f. The Chairman, upon receipt of information from the Executive Secretary concerning each new complaint, shall determine whether the first investigation or action on the complaint merits a special called meeting of the Board or should await the next regular meeting of the Board.

5-g. When an investigation has convinced the members of the Board (not including the member in whose county the physician under investigation resides) that no disciplinary action is indicated and that both the complainant and the physician involved are willing to accept the advice of the Board for reconciliation of the complaint, the advice and suggestions of the Board shall be reduced to writing and supplied to both complainant and the physician concerned, over the signature of the acting chairman.

5-h. When an investigation convinces members of the Board that disciplinary action is indicated, the entire Board except the member whose county is involved shall consider the matter formally in meeting before further action is taken, and the recommended action shall be determined by majority vote of those present. The evidence in the case and the Board's recommendation shall then be sent to the Council for disciplinary action.

5-i. When, after investigation and attempts to effect amicable settlement, the Board is unable to reconcile differences over a fee charged by a member of the Association, the Board shall by a majority vote determine a fee which it deems fair and proper in this specific case. In case the Association member shall agree to the amount so fixed and shall fail to abide by his agreement, the Board shall cite such member before the Council for contempt proceedings. Failure of the member to agree to such determination of the Board of Appeals shall constitute grounds for the preferring of charges of unprofessional conduct under the principles of ethics, before the Council.

5-j. Whenever the Board recommends that charges should be filed against a member of the Association with either a Board of Censors of the county society, the Indiana State Board of Medical Registration and Examination, or with a criminal court, the charges shall be reduced to writing and filed with the Council over the signature of two officers of the Board and over the typed names of all other members of the Board who have taken part in the proceedings.



In the event that, in consideration of a case involving complaint against a physician who is not a member of the Medical Association, it is determined that the evidence does or does not justify proceedings before the State Board of Medical Registration and Examination or a criminal court, the Board shall reduce its findings to writing, and subject to advice of legal counsel, shall in either case notify the physician concerned of its findings and shall file a copy of this notice with the executive office of the State Association and the Secretary of the State Board of Medical Registration and Examination for future reference.

5-k. Both the original complainant and the physician against whom the complaint has been made will be furnished with a written statement and explanation of the final decision of the Board as soon as possible after the Board has completed its investigation of this case, whether (1) the Board considers the case closed, or (2) decides to take further procedure.

5-l. Any announcements or news releases prepared by the Board for issuance to the public must first be approved by the Association's standing Committee on Publicity. Copies of these press releases when approved shall then be sent by the Committee on Publicity to all publications in Indiana regularly supplied with press releases by the committee and to all component county medical societies for their information and for use in the county society's public relations program.

5-m. The minutes, complaints, reports of investigation and all other correspondence and records of the official transactions of the Board of Appeals shall be kept in a locked box or compartment in the headquarters office and shall only be accessible to the Executive Secretary and the members of the Board except on special order from the Board or the Council.

5-n. It shall be the duty of the Chairman and Secretary of the Board to prepare quarterly reports of the progress and transactions of the Board for presentation at the quarterly meetings of the Council and an annual report and recommendation to the House of Delegates. These reports must first be approved by a majority vote of members of the Board present at an official Board meeting.

5-o. The annual organization of the Board and election of officers shall be held at the first regular meeting of the Board following the annual session of the Indiana State Medical Association. Immediately following the annual organization of the Board and election of officers, the Board shall prepare an estimate of financial requirements for the current year of the Board's operation, and request an appropriation from the Budget Committee.

This estimate shall include:

1. Necessary travel expense, meals and hotel bills, telegraph and long distance calls of members

of the Board in attending meetings and making investigations.

2. Special reporting services and attorneys' fees.
3. The service and travel expenses of special investigators when authorized by the Council or Executive Committee of the Association.
4. Special printing, office supplies, postage, stenographic service, etc., not included in the routine services of the Association's headquarters office.

The Board shall not authorize payment of travel expense for any physician, complainant or witness summoned or appearing voluntarily before the Board except when the Board votes that the expenditure is necessary to secure important testimony.

It shall be the duty of the Board to keep an accurate record of its expenditures and not exceed the appropriation granted by the Budget Committee. If the Board determines that additional funds will be needed before the end of the current fiscal year, it must present to the Budget Committee a report of expenditures, an estimate of additional funds needed and a request for an additional appropriation.

5-p. Regular meetings of the Board of Appeals on Patient-Physician Relations will be held on the second Sunday of January, March, May, July, September, and November, subject to the privilege of the Chairman of the Board to change or postpone any such meeting if the date is considered impractical or the meeting not necessary.

Special meetings of the Board may be called by the Chairman, or any three members of the Board, at any time after seven days notice is given.

Five members of the Board shall constitute a quorum and Robert's Rules of Order shall govern the transaction of business.

5-q. This declaration of the Authority for, and the purposes, rules and procedure of the Board of Appeals on Patient-Physician Relations shall be printed in booklet form and mailed, together with a copy of the current Principles of Ethics of the American Medical Association, to all present members and the incoming members of the Indiana State Medical Association with an accompanying letter signed jointly by the President of the Association and the Chairman of the Council.

### Amendments

These rules, purposes and methods of procedure of the Board of Appeals shall not be waived or nullified by the Board or by any component County Medical Society, its officers or committee, in the consideration or action on any complaint.

Amendments to these rules, etc., may be made by majority vote of the Board at a regular meeting and then must be approved by a majority vote of the Council of the Indiana State Medical Association at a regular meeting of the Council.

## INDIANA SURVEY ON NURSING EDUCATION\*

**F**ACILITIES for nursing education in Indiana must be improved, possibly by consolidation, with all schools ultimately accredited nationally and all programs on a level of instruction comparable to that of colleges if the state is to be able to produce the kind of nurse the public requires at all. This is the conclusion reached by Dr. Genevieve K. Bixler in a comprehensive survey of nursing education in the state, just released.

Financed by the Eli Lilly Endowment, the Indiana State Medical Association, the Indiana Hospital Association and the nurses of the state, the study was undertaken as a first step in solving the state's need for more well informed nurses—a need which is becoming an increasingly serious problem. It was sponsored by the Indiana State Nurses' Association, the Indiana State League of Nursing Education and the State Board of Nurses' Registration and Nursing Education. In her field work Doctor Bixler was assisted by Miss Margene Faddis, a member of the faculty of Western Reserve University and the author of several books on nursing, and Dr. Roy W. Bixler of Drake University. The 24 schools of nursing in the state were given thorough scrutiny.

Doctor Bixler and her associates in the survey have had considerable experience in similar studies and in writing in the field of nursing or nursing education. In 1945 she made a similar survey of nursing in Michigan and has participated in numerous research projects as director or consultant. She is a research consultant at Western Reserve University.

One of the grave problems in Indiana, true also of other states, is that many of her schools are small and, as Doctor Bixler observes, "the small schools cannot be strong schools without being so expensive as to be impractical to operate." Among the real difficulties faced by our present small schools are the employment of a truly qualified instructional staff, and the development of excellent facilities. Lack of finances to do this has resulted in a poor status of In-

diana's students in the national picture. It is felt that steps must be taken at once to improve facilities for the education of nurses.

The report suggests a ten year plan which includes the organization of additional central schools of nursing through consolidation of several existing schools, reorganization of programs in the state university and making all advanced programs under the aegis of Indiana University, plus provision for state-wide experimentation and research in nursing under state university leadership.

From their study of the schools the survey team concluded that education of nursing students seems to be secondary to giving nursing service to the hospitals in which they are located. There is a shortage of well prepared instructors. They point out that 72 nursing educators and directors are graduates of the school in which they work, a practice educators frown upon. They also found some hospitals "outgrown, out of date and inconvenient, with the facilities for education of nurses similarly inadequate." The researchers feel that some students fail to know what constitutes total nursing care. They conclude that the pattern of nursing education should be similar to that in medicine, that a major portion of it be devoted to instruction followed by an internship.

The researchers point out the educational soundness of the program now under way at Holy Cross Central School and suggest that St. Mary of the Woods serve several of the schools of the state, such as St. Mary's of Evansville and St. Anthony's of Terre Haute. They advise furthering the association of DePauw and Methodist hospital, feel that Evansville and Butler universities are well qualified to enter the field.

They observe that Purdue University has excellent resources for the initiation of a program of nursing education because of its "concentration upon scientific aspects of higher education, including sciences of nutrition, home and institutional management, and its library, laboratories and residences."

It was recommended that in Indiana Univer-

\* Release from Indiana State Nurses' Association.



sity there should be a dean of nursing with the school centered upon the Indianapolis Medical Center campus in adequate space and courses offered in the graduate field, particularly with a view to training instructors and administrators.

With preparation of nurses improved, there naturally would follow an improvement in nursing care, which, the report states, should be augmented by a well-planned program of in-service education for all practicing nurses. Also, they feel that two or three additional programs for

licensing practical nurses, such as that now in effect in Indianapolis, should be instituted.

Pointing out that this whole new concept of nurse education is the responsibility not only of the nursing and teaching professions but of communities and individuals to provide the best means of safeguarding health, the researchers say, "If it should be said that the proposed changes will be too expensive in these times, one must counter with the question, 'What other times are there?'"

## *Indiana University News Notes*

Dr. R. N. Harger, chairman of the Departments of Biochemistry and Pharmacology of the I. U. School of Medicine, was recently elected president of the American Academy of Forensic Sciences during the annual convention in Atlanta, Georgia. Dr. Robert Forney, also of the department, attended the meeting with Doctor Harger.

Approximately thirty members of the Indiana Association of Pathologists held an all day meeting on the Medical Center campus March 30. Roentgenologists of the state were invited guests for the meeting which was devoted to an economics seminar.

Dr. Carl P. Huber, director of the department of Obstetrics and Gynecology of the I. U. School of Medicine, was installed as president of the newly formed American Academy of Obstetrics and Gynecology at the annual meeting of the American Congress on Obstetrics and Gynecology recently held in Cincinnati. Doctor Huber was already a member of the Board of Directors of the Committee on Maternal Welfare which sponsors the congress.

Dr. C. O. McCormick, Sr., and Dr. G. W. Gustafson, also members of the School of Medicine staff, presented papers during the meeting in Cincinnati.

Dr. J. L. Arbogast, director of the Clinical Laboratories of the Medical Center, has been appointed chairman of Postgraduate Education for the North Central Group of the College of American Pathologists. He also has been appointed to the office of secretary-treasurer of the recently established Marion County Blood Banks, Inc., a cooperative organization including all hospitals in the area to facilitate the procurement and exchange of blood between the hospital blood banks who are members.

A number of physicians from Indianapolis and over the state attended the Fifth Annual Symposium on Malignancy conducted at the School of Medicine April 2. The same speakers for the Symposium, which is presented each year as one of the postgraduate activities of the School of Medicine, took part in a roundtable discussion for the April Telephone Seminar, the evening before. Speakers for the program, which was devoted to Cancer of the Breast, were: Dr. Lauren V. Ackerman and Dr. Eugene M. Bricker, Washington University; Dr. Shields Warren, Dr. Grantley W. Taylor and Dr. Ira T. Nathanson, Harvard Medical School; Dr. Murray M. Copeland, Georgetown University; Dr. Cushman D. Haagensen, Columbia University, and Dr. U. V. Portmann, Cleveland Clinic Foundation.

Dr. Herbert Gaskill and Dr. Philip F. G. Seitz attended a meeting of the Group for Advancement of Psychiatry, held at Asbury Park, New Jersey.

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Nineteen specialists of the ear, nose and throat field attended the 32nd annual anatomical and clinical postgraduate course in otolaryngology offered by the Indiana University School of Medicine. The two weeks course was given this year under the direction of Dr. Marlow W. Manion with the cooperation of the Medical School staff. For many years the course was directed by Dr. Carl H. McCaskey, who retired several months ago as head of the department and director of the course.

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Dr. L. W. Freeman presented a paper before members of the Southern Neurosurgical Society which met recently in Durham, North Carolina. Dr. Robert Heimbürger, also of the Department of Surgery of the I. U. School of Medicine, attended the meeting.

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Dr. Maurice Levine, professor and head of the Department of Psychiatry of the University of Cincinnati Medical School and Cincinnati General Hospital was the guest speaker for the monthly Psychosomatic Forum presented at the Medical Center. His subject was "Essence of Psychotherapy."

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The section meeting of the Association for Research in Ophthalmology held on the Medical Center campus recently brought leading ophthalmologists from midwestern states to the campus. Dr. T. F. Schlaegel and Dr. Fred Wilson of the Medical School staff were among the nine members of the Association to present papers during the day's meeting. Other papers were presented by Dr. A. C. Krause, University of Chicago; Dr. W. B. Hepner, University of Texas; Dr. G. W. Bounds, Jr., Dr. R. G. Janes and Dr. P. J. Leinfelder, University of Iowa; Dr. Thomas P. Kearns, Mayo Foundation; Dr. Paul H. Ripple, Washington University; Dr. Paul W. Miles, Washington University; Dr. Albert J. Alter, Toledo, Ohio, and Drs. A. E. Braley and R. C. Alexander, University of Iowa.

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Dr. V. K. Stoelting of the Department of Anesthesiology was recently notified he was made an honorary member of the Sociedade Brasileira de Anesthesiologia.

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Several members of the Medical School staff were in New York the week of April 13 attending sessions of the Federated American Societies for Experimental Biology. Dr. Randall Thompson presented a paper during one of the programs. Others attending were Dr. L. W. Freeman, Dr. Robert Dryer, Dr. Donald Bowman and Dr. R. N. Harger.

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#### STUDENT AMA GROWS

Three new chapters have applied for membership in the Student American Medical Association, bringing the total number of active and provisional chapters to 47. The new groups are located at Western Reserve University, the University of Southern California and the State University of New York at Brooklyn. Organizational plans are being developed at other schools, including Northwestern, Vanderbilt, Tennessee, Cincinnati, New York Medical College, Iowa, North and South Carolina, Minnesota and West Virginia. Recently, the SAMA's executive council voted to change the annual meeting date from December to June, effective with the 1953 meeting.



News Notes

The American Congress  
of Physical Medicine

The 30th annual scientific and clinical session of the American Congress of Physical Medicine will be held on August 25, 26, 27, 28 and 29, 1952 inclusive, at The Roosevelt Hotel, New York, N. Y. All sessions will be open to members of the medical profession in good standing with the American Medical Association. Full information may be obtained by writing to the American Congress of Physical Medicine, 30 North Michigan Avenue, Chicago 2, Illinois.

Rocky Mountain Cancer Conference

Indiana physicians are invited to attend the sixth annual Rocky Mountain Cancer Conference, at the Shirley-Savoy Hotel in Denver, July 9 and 10. Eight guest speakers will discuss the latest advances in the diagnosis and treatment of cancer. This conference annually attracts more than 600 physicians from 20 states. For information address the Rocky Mountain Cancer Conference, 835 Republic Building, Denver 2.

Army Selects 146 Senior Medical Students  
For Intern Program

Appointment of 146 senior medical students for the Military Intern Program of the Army Medical Service has been announced by Major General George E. Armstrong, Army Surgeon General.

The program, scheduled to get under way July 1, provides that medical students, upon graduation, can be commissioned as first lieutenants in the Medical Corps Reserve and serve their internships in Army hospitals.

Residents of Indiana named to the Army Military Program are listed below with the hospital to which they are assigned:

Name	Home Town Address	Army Hospital Assignment
Arendell, Robert E.	Elberfeld	Tripler
Curran, Francis J.	Indianapolis	Walter Reed
Gonzales, Hector H.	Indianapolis	Madigan
Steigmeyer, David J.	Fort Wayne	Brooke

Annual Convention of the International  
Academy of Proctology

The International Academy of Proctology will hold its Fourth Annual Meeting in Chicago, June 6, 7, and 8, at the Edgewater Beach Hotel.

The first two days will be devoted to a Seminar presentation of papers relating to the colon and rectum. The entire day of June 8 will be devoted to a teaching film presentation of surgical techniques for diseases of the colon, rectum and anus.

All physicians are cordially invited, whether or not affiliated with the International Academy of Proctology. There will be no registration fee.

National Gastroenterological Association  
1952 Award Contest

The National Gastroenterological Association again takes pleasure in announcing its Annual Cash Prize Award Contest for 1952. One hundred dollars and a Certificate of Merit will be given for the best unpublished contribution on Gastroenterology or allied subjects. Certificates will also be awarded those physicians whose contributions are deemed worthy.

All entries for the 1952 prize should be limited to 5,000 words, be typewritten in English, prepared in manuscript form, submitted in five copies accompanied by an entry letter, and must be received not later than 1 September 1952. Entries should be addressed to the National Gastroenterological Association, 1819 Broadway, New York 23, N. Y.

South Bend Medical Foundation Anniversary

The fortieth anniversary of the South Bend Medical Foundation was celebrated at a dinner on April 30. South Bend physicians and other prominent citizens gathered to commemorate the successful development of the foundation from humble beginnings, and to pay tribute to A. S. Giordano, M.D., who has served as its director for thirty years. Robert Moore, M.D., Edward Mallinckrodt professor of pathology and dean of the Washington University School of Medicine, St. Louis, was the principal speaker.

### Editorial Assistants—Collaborators

A clearinghouse service on *competent* editorial assistants or collaborators to assist in the preparation of papers for meetings, publication or clinical demonstrations is being established. Technicians qualified to assist in editing explanatory or sound tract material in conjunction with professional motion pictures are included. Information will be available to *all* members of the medical profession on request.

Please assist this NEW service by forwarding names and addresses of qualified collaborators to Academy-International of Medicine, 214 West Sixth St., Topeka, Kansas.

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At the fourth annual session of the **Indiana Academy of General Practice** in Indianapolis, in April, the following officers were elected: **William Tindall, M.D.**, Shelbyville, president-elect; **Clifford M. Jones, M.D.**, Whiting, vice-president; **Norman R. Booher, M.D.**, Indianapolis, re-elected secretary-treasurer. Doctor Booher and **William Troutwine, M.D.**, of Crown Point, were appointed delegates to the national convention; and **Floyd Boyer, M.D.**, Indianapolis, **Frank Green, M.D.**, Rushville, **James Lamey, M.D.**, Anderson, and **Charles L. Alvey, M.D.**, Muncie, were elected to the Board of Directors.

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**Dr. Francis W. Hare, Jr.**, has joined the Madison Clinic at Madison, where he will specialize in internal medicine. He is a graduate of Duke University School of Medicine. He spent two years in the Army, following his internship, and then served as resident at the City Hospital in Akron, Ohio, and as pathologist at Louisville General Hospital. Doctor Hare has also been a medical fellow at the Lahey Clinic in Boston.

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**Dr. M. Dale Kinzie**, of Goshen, has discontinued his practice there to enter the air force. He reported to Gunter Field, in Montgomery, Alabama, for active duty on April 14.

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**Dr. Harry McClelland**, who was formerly associated with the Bluffton Clinic in Bluffton, has opened an office for the practice of medicine in Alexandria.

### Change in Directors of Ball Memorial Hospital

Ball Memorial Hospital directors yesterday named Walter G. Ebert of Marietta, Ohio, as Administrator of the hospital, succeeding Nellie G. Brown, who will soon retire from the superintendency of Ball Memorial and a career in hospital work that spans nearly a half-century. Both Miss Brown's resignation and Mr. Ebert's appointment will become effective July 1.

Mr. Ebert, a native of Parkersburg, West Virginia, will resign as director of Marietta Memorial Hospital, a 100-bed institution, to accept his new assignment here. He served the Navy 24 years, from 1926, when he entered the Naval Academy at Annapolis, until the latter part of 1950, when he retired with the rank of Rear Admiral. Mr. Ebert was then 41, and became the youngest man in naval history to be commissioned to that high rank. For a year before he left the Navy, Mr. Ebert pursued an intensive course of study in preparation for a career in the field of hospital administration.

When she retires next July, Miss Brown will have served Ball Memorial Hospital exactly one month over 23 years. She came to Muncie June 1, 1929, two months before completion and opening of Ball Memorial, a modern hospital facility made available to the community by the Ball Foundation.

Miss Brown came to Muncie following a 14-year tour of duty with the Indiana University Hospitals, now known as Indiana University Medical Center, Indianapolis, where she was first an instructor and later assistant director of the university's School of Nursing.

Nellie Brown was Ball Memorial's first director of nurses and head of the hospital's School for Nurses. She served in that capacity until the Fall of 1932 when the trustees named her Acting Superintendent. In 1933, following the death of Harold K. Thurston, Miss Brown succeeded to the superintendency.

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**Dr. Albert J. Grant**, of Philadelphia, Pennsylvania, has opened an office for the practice of medicine in Monterey. He is a graduate of Jefferson Medical College, of Philadelphia.



**Drs. Charles F. Leich** and **Paul E. Strueh** of Evansville have announced that **Dr. Walter J. Maher**, of New York City, will become associated with them in practice as of July 1. Doctor Maher is replacing **Dr. Thomas W. Wesson**, who is returning to Tupelo, Mississippi, to practice. Doctor Maher, who will confine his practice to ophthalmology, is a graduate of St. Louis University School of Medicine. He is a veteran of World War II, took postgraduate work in ophthalmology at New York University, was resident in ophthalmology in Bellevue Hospital, and has been in private practice in New York.

**Dr. Guy Morford**, of Kokomo, has moved to Owensboro, Kentucky, where he has established practice.

**Dr. Harry McClelland** has opened an office for the practice of medicine in Alexandria. He is a graduate of Indiana University School of Medicine, served for four and one-half years with the Army in World War II, and spent his internship and a three year residency at Indiana University Medical Center.

**Dr. W. R. VanDenBosch** has been named superintendent of the Norman Beatty Hospital at Westville. He has been at the hospital since its opening, serving as the late Dr. Herbert McMahan's assistant.

#### A.M.A. WASHINGTON OFFICE NEWS

### Budget Bureau Proposes 'Single, Fully Integrated' Military Medical Service

The Budget Bureau, testifying in opposition to a Hoover Commission bill (S 1140) for creation of a Department of Health, told a Senate Committee that commission objectives can best be obtained "by developing within the Department of Defense itself *a single, strong and fully integrated medical service*." Fred A. McNamara, chief of the Bureau's hospital branch, testified the Bureau felt that "this function is readily susceptible to complete unification." Then, he added:

"As an immediate step in that direction, it is essential that the merely advisory role of the *Armed Forces Medical Policy Council* be terminated and its functions strengthened greatly so as to (1) provide over-all policy direction and control, (2) place responsibility centrally for effective and integrated program and construction planning and review of the total medical services of the Department and (3) provide for the unified operation of . . . medical procurement and supply, education and training, medical research, blood plasma management, medical and allied professional personnel procurement."

The Bureau official recalled that the Hoover Commission recommended establishment in the Defense Department of a strong control over medical policy at the Secretary of Defense level and had proposed an advisory committee composed principally of civilian physicians and a dentist, together with the Surgeons General of the three military services. He said such a committee (the Council) was immediately established and since has been "very effective in developing Defense Department-wide standards and policies, principally in professional medical and personnel areas."

First chairman of the Armed Forces Medical Policy Council was Dr. Richard L. Meiling, who took over when the Council was created in January, 1951. Dr. Meiling had served up to that time as director of the Office of Medical Services, which preceded the Council. He continued as Council chairman until June 30, 1951 and was succeeded by Dr. W. Randolph Lovelace II, who served until March 31, 1952, when Dr. Melvin A. Casberg, then vice chairman, became chairman.

**SUPREME COURT RULES IN FAVOR OF OREGON MEDICAL SOCIETY**

The United States Supreme Court in a seven to one decision April 28, dismissed an appeal of the government against the Oregon State Medical Society, eight county medical societies, Oregon Physicians Service, and several physicians who are or were officials of these organizations. Previously a U.S. District Court had ruled against the government's antitrust violation charge and a direct appeal had been taken to the U.S. Supreme Court.

The controversy in Oregon began in 1936 when the medical society opposed contract practice of medicine sponsored by private firms and commercial insurance companies. At that time the medical society charged that medical treatment and service was dependent upon company approval and in some cases the advice of physicians was disregarded. The medical society raised the ethical objection that third parties were entering the doctor-patient relationship. The medical society in an effort to bring about reform of prepaid medical service within the state, decided in 1941 to render itself such service on a nonprofit basis. After seven years of successful operation of the society plan the government brought suit charging the society with monopolizing the business of providing prepaid medical care within the state.

The Supreme Court said at one point, "Objections of the organized medical profession to contract practice are both monetary and ethical. Such practice diverts patients from independent practitioners to contract doctors. It tends to standardize fees. The ethical objection has been that intervention by employer or insurance company makes a tripartite matter of the doctor-patient relation. Since the contract doctor owes his employment and looks for his pay to the employer or the insurance company rather than to the patient, he serves two masters with conflicting interests. In many cases companies assumed liability for medical or surgical service only if they approved the treatment in advance. There was evidence of instances where promptly needed treatment was delayed while obtaining company approval, and where a lay insurance official disapproved treatment advised by a doctor."

And at another point the Court said, "Since no concerted refusal to deal with private health associations has been proved, we need not decide whether it would violate the antitrust laws. We might observe in passing, however, that there are ethical considerations where the historic direct relationship between patient and physician is involved which are quite different than the usual considerations prevailing in ordinary commercial matters. This Court has recognized that forms of competition usual in the business world may be demoralizing to the ethical standards of a profession."

Mr. Justice Clark, who was formerly the Attorney General of the United States, took no part in the consideration or decision of the case, probably for the reason that the government suit was commenced during the time while he was serving as Attorney General.

Mr. Justice Black, the lone dissenter, did not write a minority opinion. The majority opinion was written by Mr. Justice Jackson.

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**Murray and Dingell Introduce Bills  
For Hospitalization-At-Age-65**

Senator Murray and Rep. Dingell have introduced identical bills to authorize establishment of a system of government-paid hospitalization for everyone eligible for social security benefits. Eligibles would include persons 65 and over who are covered by social security and their dependents as well as the survivors of deceased persons so insured. Hospital benefits would be limited to 60 days in any one calendar year.

Some of the provisions: 1. Beneficiaries would be eligible for drugs, services and appliances "customarily furnished by such hospital to its bed patients," but tuberculosis or mental hospitals "or any hospital or institution which furnished primarily domiciliary or nursing care" could not participate in the program. 2. A physician would have to determine that hospitalization was required. 3. Although costs would be paid out of the Social Security Trust Fund, state departments of health would handle details. The states could, if they so decided, turn administration over to Blue Cross or other non-profit insurance organizations.



### Adm. Boone Explains How Budget Cut Would Restrict VA's Medical Program

Explaining that he was acting after receiving a number of inquiries, VA Medical Director Joel T. Boone has described the ways in which the proposed budget cuts would affect the administration's medical program. Reductions were approved by the House, but the Senate has not yet acted.

If the reductions are carried out, Adm. Boone said it will be "virtually impossible" to continue the VA residency training program and that large numbers of beds will have to be closed down. His estimate was that 1,600 department employees would have to be dropped in the next fiscal year, that one half of VA's research laboratories would have to be shut down and that there will be a drastic cut in fees for medical consultants, which will result in restricting the residency program.

Adm. Boone listed several alternatives: (a) older hospitals, expensive to maintain, could be closed, or VA could close those in isolated communities which are difficult to staff, (b) large numbers of beds could be closed throughout the country on a prorated scale, or the opening of 24 new hospitals scheduled for completion next fiscal year could be delayed.

The medical director said that the last alternative will not be used because the new modern hospitals can be operated at minimum cost and are located in areas where staffing problems will be at a minimum. Closing the older hospitals would be difficult, he said, because many of them are occupied by TB and NP cases, where the turnover is slow and where transfer of patients is difficult. He concluded that if the budget reductions are insisted upon, the final decision probably will have to be to close some older hospitals and some in isolated communities and to use a prorated plan for closing a certain number of beds throughout the system.

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#### 70% OF FEDERAL CIVIL DEFENSE FUNDS GO FOR MEDICAL PURPOSES

Approximately 70% of all federal money spent on civil defense is going for *medical purposes*, principally matching grants to states for local medical stockpiling and all-federal regional stockpiles. This breakdown of Federal Civil Defense

Administration activities is contained in Administrator Millard Caldwell's annual report, covering the first full year's operations of FCDA. So far FCDA appropriations for all purposes have totaled about \$100 million. Of this, \$50 million is earmarked for all-federal medical purchases. \$20 million will be used either for federal medical purchases or matching grants to states.

By next June, the report estimates that about \$90 million in medical supplies will have been procured or will be on order, the extra \$20 million to come from non-federal sources.

During 1951, FCDA prepared and sent to regional, state and local civil defense directors specifications for about 200 individual medical items. Using these specifications, state and local civil defense organizations may do their own ordering, or order through FCDA, which makes use of the Armed Services Medical Procurement Agency for purposes of coordination and economy.

The report says that within the next year a total of 58 regional warehouses will be available for stockpiling of federal supplies, including engineering as well as medical. In federal warehouses, a system of "unitizing" is used, and FCDA officials are encouraging state and local officials to employ a similar technique. On this the report says, "Supplies must be warehoused in such a way that they are *immediately available* at time of emergency. This requires 'unitizing'. Instead of all items of a given type, such as surgical instruments, being stored in one area of a warehouse, items making up a unit are stored together. For example, present plans call for storage of medical supplies and equipment in units necessary for a 200-bed emergency hospital." States are being urged to store their own supplies in units sufficient to care for 1,000 casualties.

In case of an emergency, the local community will have to depend on its own medical supplies and services for the first few hours, awaiting the arrival of medical units from the nearest federal regional warehouse.

On the federal level, plans are being made for exchange of perishable medical supplies with other government agencies, while states expect to rotate their own perishable items with state hospitals and other institutions.

## Deaths

**Daniel W. Layman, M.D.**, of Indianapolis, died on April 21, at the age of seventy-nine. He had been in practice for fifty years. He was a graduate of Columbia University College of Physicians and Surgeons, in New York, in 1898. Doctor Layman was an honorary member of the Indianapolis Medical Society and the Indiana State Medical Association, and was a member of the American Medical Association.

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**Charles F. Pectol, M.D.**, of Spencer, died on April 7, at the age of eighty-five. He was a graduate of the Louisville Medical College in 1898, and had practiced in Owen County for fifty-four years. He was a member of the Owen-Monroe County Medical Society, the Indiana State Medical Association, and the American Medical Association.

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**Harrison C. Ragsdale, M.D.**, of Bedford, died on April 26, at the age of fifty-seven. He graduated from Indiana University School of Medicine in 1920, and had practiced in Bedford for twenty-seven years. He served as Councilor for the Indiana State Medical Association from 1932 to 1937. Doctor Ragsdale was a veteran of World War II, and was a member of the Lawrence County Medical Society, the Indiana State Medical Association, and the American Medical Association.

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**David C. Ridenour, M.D.**, of Peru, died on April 25 after a long illness. He was eighty-three years old. He retired in 1947, after being in practice for thirty-five years. He was a 1892 graduate of the Starling Medical College of Columbus, Ohio, and had practiced in Peru since that time. Doctor Ridenour was an honorary member of the Miami County Medical Society and the Indiana State Medical Association, and was a member of the American Medical Association.

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**Alfred C. Bartholomew, M.D.**, of Fort Wayne died on April 27 after a brief illness. He was seventy-two years of age. A 1901 graduate of the University of Michigan Medical School, at Ann Arbor, he practiced in Logansport, South Bend, and at Van Wert, Ohio, before establishing a practice in Fort Wayne, where he had practiced for thirty years. Doctor Bartholomew was a member of the Allen County Medical Society, the Indiana State Medical Association, and the American Medical Association.

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**Roger W. Brookie, M.D.**, of Flora, died suddenly on April 22 at Tilton, Georgia, while enroute from Florida to his home. He was sixty-nine years of age. He graduated from Northwestern University Medical School, in Chicago, in 1908, and practiced in Flora from 1937 until shortly after the end of World War II, when he retired. Doctor Brookie was a veteran of World War II, and was a member of the Carroll County Medical Society, the Indiana State Medical Association, and the American Medical Association.

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**Walter J. Cluthe, M.D.**, retired physician of Evansville, died on April 7, at the age of seventy. A graduate of the Kentucky University Medical Department, in Louisville, in 1903, he practiced in Tell City and Kansas City, Missouri, until he retired, twenty years ago, when he moved to Evansville.

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**Joseph M. Heberer, M.D.**, of Evansville, died on April 2, at the age of seventy-three. He had practiced in Evansville for fifty-two years. He was a 1900 graduate of the Louisville Medical College, and was a member of the Vanderburgh County Medical Society, the Indiana State Medical Association, and the American Medical Association.



## Society Reports

### INDIANA STATE MEDICAL ASSOCIATION

#### THE COUNCIL

April 26, 1952

The Council of the Indiana State Medical Association convened for its spring meeting at 6:30 p.m., Saturday, April 26, 1952, in the Harrison Room, Columbia Club, Indianapolis, with Dr. Wemple Dodds, chairman, presiding.

Roll call showed the following present:

#### Councilors:

First District	-----	Herman T. Combs, Evansville Paul D. Crimm, Evansville, alternate and president-elect
Second District	-----	A. G. Blazey, Washington
Third District	-----	William H. Garner, New Albany
Fourth District	-----	Charles Overpeck, Greensburg
Fifth District	-----	M. C. Topping, Terre Haute V. Earle Wiseman, Greencastle, alternate
Sixth District	-----	Not represented
Seventh District	-----	Roy A. Gelder, Indianapolis
Eighth District	-----	T. R. Hayes, Muncie, alternate
Ninth District	-----	Wemple Dodds, Crawfordsville Harry E. Klepinger, Lafayette, alternate
Tenth District	-----	William H. Howard, Hammond
Eleventh District	-----	Elton R. Clarke, Kokomo
Twelfth District	-----	M. B. Catlett, Fort Wayne
Thirteenth District	-----	Kenneth L. Olson, South Bend G. O. Larson, LaPorte, alternate

#### Officers:

J. William Wright, Indianapolis, president  
 Frank B. Ramsey, Indianapolis, editor of THE JOURNAL  
 C. J. Clark, Indianapolis, chairman, Executive Committee  
 W. L. Portteus, Franklin, member, Executive Committee  
 James A. Waggener, executive secretary  
 Albert Stump, attorney  
 Robert J. Amick, field secretary

#### Guests:

Alfred Ellison, South Bend, A.M.A. delegate  
 F. S. Crockett, Lafayette, A.M.A. delegate  
 Karl R. Ruddleil, Indianapolis, A.M.A. alternate  
 James W. Denny, Indianapolis, chairman, Committee on Medical Education and Hospitals  
 A. P. Hauss, New Albany, chairman, Board of Appeals on Patient-Physician Relations  
 Maurice V. Kahler, Indianapolis, chairman, Permanent Study Committee on Medical Care Insurance

By consent, the minutes of the midwinter meeting of the Council, held at Indianapolis on January 13, 1952, were approved as printed in the March, 1952, issue of THE JOURNAL.

#### Reports of Councilors

The councilors announced the dates and places of their spring district meetings and invited the officers of the association to attend.

*Jefferson-Switzerland County Medical Society.* Doctor Overpeck read the following communications:

"We, the undersigned, licensed, practicing physicians of Switzerland county, located in Vevay, Indiana, desire to become joint members of the Jefferson County Medical Society:

GEORGE E. ELLERBROOK, M.D.  
 THEODORE C. PERSON, M.D.  
 NOEL S. GRAVES, M.D.  
 L. H. BEAR, M.D.  
 G. W. COPELAND, M.D."

"Dear Dr. Overpeck:

"The members of the Jefferson County Medical Society would be happy to have the members of the Switzerland County Medical Society join with us into one group.

Sincerely,

(Signed) MARCELLA S. MODISSETT, M.D.,

16 April 1952

Secretary."

On motion of Drs. Overpeck and Catlett the Council granted the request of the Switzerland county physicians to join with the Jefferson County Medical Society, the joint society to be known as the Jefferson-Switzerland County Medical Society. The executive secretary is to notify the Switzerland county physicians that they have been given permission to join up with Jefferson county.

*Pre-Council meetings.* Councilors from the Fifth, Tenth, Eleventh, Twelfth, and Thirteenth Districts reported that successful pre-Council meetings had been held with the county society officers and delegates in their respective districts.

#### Reports of Officers

*Dr. J. William Wright, President 1952:*

"The chairman has suggested it might be well for me to make, as a part of my report, a few statements regarding the operation of our headquarters office. It has been my experience, and that of others to whom I have talked, who have had an opportunity to see our headquarters staff at work, to be somewhat surprised at the volume of work which takes place in our office. One has no idea, until you have the opportunity to work closely with our office and spend sufficient time in going over the many details that require constant attention, just what the headquarters office is, what it does and why.

"The first thing I would like to point out is that the headquarters office of our association is made up through the membership of our association, and is charged with the responsibility of carrying out the many responsibilities and duties assigned it by the House of Delegates, the Council and the Executive Committee. It maintains at all times an up to date record of physicians in Indiana, their addresses, both office and home, education and a record of the duties performed by each, such as service on committees, etc. Our headquarters office

can tell you exactly what year you graduated from medical school and the school from which you graduated, where you interned, when you began practice. The reason for this, not a day goes by but what many requests are received from physicians, the public, the press and others desiring all or part of this information.

"Our headquarters office and staff carry out all the policies and instructions given it by the various bodies of the association and in addition handle the business of some 40 different committees. These duties include sending out notices of meetings, making the arrangements for the meetings, preparing the agendas under the advice of committee chairmen, and preparing and distributing the minutes of these meetings, plus putting into operation the decisions of our various committees.

"The bookkeeping of our office is quite extensive, books must be kept on all income and money expended. The budget is prepared and the many activities of our committees are properly charged against their budget. You can well imagine the volume of record keeping necessary in handling the dues payments and financial records of some 3,500 to 4,000 physicians.

"The volume of correspondence handled through our headquarters office is somewhat astounding. This correspondence covers every subject, from asking the attitude of physicians toward socialized medicine and requests from our members asking every conceivable question, to appeals for assistance in receiving medical aid, not to mention the many letters complaining about the treatment received by patients at the hands of some of our members. In handling this mail and telephone requests, our headquarters office is daily spending hours in preparing correspondence to answer these many requests for information, lending assistance to those making the request when possible, giving advice and soothing the tempers of many of our patients. In making a study of the volume of mail matter that goes out of our office, I found that in a period of between January 1 and April 9 of this year, 21,584 pieces of mail have been sent out. I might add this figure includes the mailing of the news letter but does not take into consideration the parcel post shipments, *THE JOURNAL*, nor the multiple enclosures in many of the mailings.

"I found that our executive secretary in this same period of time has represented us in 72 meetings of one sort or another and has filled four speaking engagements.

"In addition, *THE JOURNAL* which we receive every month is handled by a staff of two working with our editorial board in collecting the information, and preparing it for printing, plus the obtaining of the advertising to pay the publication deficit brought about by the small part of our dues we pay as a subscription fee.

"I will not at this time go into a more detailed statement of the operation of our state office in its

relation to our various committees. Instead, I have requested our executive secretary to make a more detailed report before the House at its meeting tomorrow.

"The Executive Committee at its May meeting employed Mr. Robert J. Amick as our field secretary, following the refusal of Mr. Branson to accept the position. Mr. Amick began his duties on April 1, and since that time he has contacted 21 of our southern societies. Our secretary will cover this in more detail in his report tomorrow.

"Mr. Amick is a graduate of Hanover College, married, and the father of two children. He served in the Navy during World War II and recently returned from a second tour of duty with the Navy in Japan. He holds an honorable discharge with the rank of Lieutenant. He makes his home in Scottsburg which enables him to easily contact the societies in Southern Indiana.

"If this field service proves as helpful to our societies as it is apparently already doing, it is the thinking of the Executive Committee later on to attempt to work out a similar arrangement for the northern part of the state.

"I have just completed attending a series of five regional meetings throughout the state, when I had the opportunity to meet with representatives of each of our county societies for a discussion of our problems as our members see them.

"All in all, I believe our association is moving along at a good pace. I might tell you of a conversation I had with Doctor Cline, president of the AMA, at Fort Wayne last Thursday evening, following his talk before the House of Delegates of the Woman's Auxiliary. Doctor Cline said this about our operation in Indiana, 'If we had more Indianas in this nation we would not have many of the problems we face today.' Doctor Cline was most complimentary on our operation and the work we are doing. This, coming from our national president, says more than I could possibly say in a much more lengthy report."

*Dr. Paul D. Crimm, president-elect:* "As Bill Wright's man Friday, I have endeavored to carry out all of his directives."

*Dr. Frank B. Ramsey, editor of THE JOURNAL:* "I think the affairs of *THE JOURNAL* are coming along in fine style. We do need good scientific papers to publish. We have worked down from the log jam we were in two years ago. We have only two or three months' supply of articles on hand now. We would like to ask members of the Council to keep their eyes open for doctors who are doing special work on some subject, and encourage said doctor to send a paper in. . . . This would give us a little more sense of security. . . . We have been able to request articles that have been written on special subjects. . . . Some of those



have turned out very well. . . . Medical year book—this year we are planning on having a roster number without the reference articles. The main reason for that is that we have run out of subjects about which to write reference articles on. If any of the Councilors or doctors have any ideas on subjects about which you would like reference articles written, let me know, and we will get them written. If any of the previous articles need revision, we would like to know about that. . . . The roster number will have roster advertising which is a financial advantage. . . . One reference article will be on the process of adopting children in Indiana.”

### Unfinished Business

1. **Nominations for Editorial Board.** The Council made no further nominations at this time. Dr. Harold D. Lynch, Evansville (pediatrics), and Dr. Carl Culbertson, South Bend (pathology), were nominated at the midwinter Council meeting.

2. **Report of Committee on Medical Education and Hospitals.** *Dr. James W. Denny, chairman:* Mr. Chairman, members of the Council of Indiana

State Medical Association:

I wish to report some of the accomplishments of your Committee on Medical Education and Hospitals. First I want to speak about your Telephone Broadcasts.

1) Under the able guidance of Mr. Waggener and Dr. C. J. Clark's committee these have improved over last year and have gained national recognition. For instance, as chairman, I was asked to appear on the program of the American Academy of General Practice at Atlantic City last March and present in detail our experiences in this field. Being unable to attend, Mr. Waggener wrote a speech which I recorded and sent to them. I was told by several present that it was received with much enthusiasm. This same recording is now being used by the New York Academy this month at their state meeting.

2) Our committee has caused Mr. Waggener to purchase tape recording equipment and with his guidance we are rapidly building a library of scientific medical recordings. For instance, ten days ago he recorded a full days' meeting at South Bend and also the full program here in Indianapolis of the Academy of General Practice. I might add that if you hear an especially good medical paper let us know and we will be glad to invite the author to record it for us. Later we hope to publish the titles of all our subjects so that our colleagues may request them for their use or for their medical meetings.

3) We are investigating the possibilities of Television but I am unable to give you any information as to our attitude about this possibility of postgraduate education at this time.

Now I want to talk about another child of our committee, the Medical Education Foundation. When you so graciously gave this infant to us he was certainly in a birthday suit without any means of support. We've nourished him a little, as I will show you later, but he still needs much more financial feeding to achieve our goal.

On February 17, 1952, as your chairman I appeared on a program in Chicago sponsored by the A.M.A. at which there was a medical representative from each state. The meeting was entirely devoted to the Medical Education Foundation, its history, its aims and its program for raising funds and for dispensing funds. I came home with the following impressions:

1) There will be an annual campaign.

2) The medical fund will grow each year but will never equal the industrial portion of the fund.

3) The Foundation has arranged to distribute its funds to the medical schools through the national fund. Three classes of grants have been established by the national fund: Class A, Grants which are to be a uniform annual sum granted to each accredited medical school; Class B, Grants which are to be a uniform annual sum per student in each accredited medical school; and Class C, Grants which will be awarded to individual medical schools on the basis of special needs and problems. In any given year the size of the Class A and B Grants and the availability of Class C Grants will be determined on the basis of the total sum raised by the national fund for that year.

4) Indiana, in my opinion, has the best set-up for yearly campaigns of any that I heard described at Chicago and I might add I believe most of the others present were of this same opinion. Our plan is simple—each year the president-elect shall be asked to be the Honorary Campaign Chairman and in consecutive order down the line shall be the chairman of Medical Education and Hospital Committee, Mr. Waggener, chairman of each county delegation, delegates and alternate delegates as solicitors.

5) As you all know, we are in the process of getting a trust fund set up with what monies come back to I. U. and I feel this is an excellent public relations project with our medical school—even better than our telephone seminars.

6) Last year I. U. received \$15,000 from the Medical Education Foundation and this July will receive the 1952 grant.

I wish now to report actual figures of our campaign fund as given to me by Mr. Waggener, as of April 25, 1952:

Amount pledged 1 year-----	\$32,577.52
Amount pledged 2 years -----	11,424.50
Amount pledged 3 years -----	11,394.00
Amount pledged by organizations--	1,155.00

Total amount pledged ----- \$56,551.02

Number of physicians making pledges	596
Number of organizations making pledges	6
Number of physicians who have sent in contributions	569
Number of organizations which have sent in contributions	6
Total amount received and transmitted to national fund as of the close of business April 25, 1952	\$32,487.77

I wish to take this opportunity to thank Jim Waggener. He is a real work horse and has been most helpful to our committee. Without Jim's help we might fail to reach our goal but with him I'm sure we will succeed.

**3. Indiana Medical Education Foundation agreement.** Mr. Stump read the proposed agreement of the Indiana Medical Education Foundation which, in final form, will require approval of the American Medical Education Foundation and the Board of Trustees of Indiana University.

On motion of Drs. Clarke and Catlett the Council approved the agreement in principle and authorized the Executive Committee to arrange the wording in connection with the two organizations concerned.

**4. Rules and regulations governing the procedures and official actions of the Board of Appeals on Patient-Physician Relations.** Copies of the policies of the Board of Appeals had been supplied to Council members prior to the meeting. Following discussion by Dr. A. P. Hauss, chairman of the Board of Appeals, and Drs. Howard, Blazey, Crockett, Combs and Wright, on motion of Drs. Geider and Garner, the Council approved the rules as submitted. (They are published on page 514 of this issue of THE JOURNAL.)

#### 1952 Annual Session at Indianapolis

The executive secretary reported that the scientific and entertainment programs were nearing completion for the annual convention which is to be held on October 28, 29 and 30, 1952, in Indianapolis.

#### Membership Problems

**Remission of state dues.** On motion of Drs. Wright and Combs, the Council voted to remit the 1952 dues of a member of the Indianapolis Medical Society who is ill and permanently disabled. Request for remission of dues of a Boone county physician was tabled until the next Council meeting, pending receipt from the county society secretary of the reason for such request.

#### New Business

**1. Pre-Council and pre-House of Delegates meetings.** Motion by Doctor Clarke, duly seconded, for approval by the Council, for presentation to the House of Delegates, of the following resolution (passed by the Howard County Medical Society on February 1, 1952), was lost on a vote of 6 to 5:

*Resolved,* That the By-laws of the Indiana State Medical Association be amended by adding to Section 1 of Chapter VII the following as an additional paragraph:

"The agenda for each of the first four meetings provided for in this section shall be prepared and distributed to the Councilors at least four weeks prior to the date of each meeting. After receiving such proposed agenda for the meetings of the Council immediately preceding the meetings of the House of Delegates each Councilor shall hold a meeting of the county presidents, secretaries, and delegates to the State Convention within his Councilor district for the purpose of considering the recommendations and views of such presidents, secretaries and delegates, on the subjects contained in the agenda and upon any other subjects which such meetings may decide should be presented in the next meeting of the Council following such district officers' and delegates' meeting. Each Councilor may hold such a meeting before the other meetings of the Council.

"These meetings are to be obligatory for the meetings prior to the two sessions of the House of Delegates and optional for the intervening Councilor meetings depending upon the apparent need or urgency of pending topics to come before the Council."

**2. Endorsement of Association of American Physicians and Surgeons.** Approval of the following resolution, presented by Doctor Blazey, was lost on a voice vote:

WHEREAS, the retention of the present system of giving quality medical care is endangered through strong efforts to enact federal control of medical services, or socialized medicine, or compulsory sickness insurance, by way of omnibus and fringe legislation, and,

WHEREAS, the Association of American Physicians and Surgeons provides physicians with a realistic program in medical economics, public relations and legislation to meet effectively these threats to quality medical care, and

WHEREAS, the Association of American Physicians and Surgeons has for six years effectively sponsored an annual Essay Contest for high school students on the value of private practice and the evils of compulsory medical care for the factual enlightenment of the nation's future young voters, and

WHEREAS, the Association of American Physicians and Surgeons furnishes medical students and interns with information on the socio-economic aspects of medical practice to preserve the future of private quality medical care through enlightened young doctors, and

WHEREAS, the Association of American Physicians and Surgeons, in recognition of the fact that the real issue is "Human Freedom versus Socialism," sponsors an effective program of education in Freedom for all physicians and their patients, and

WHEREAS, the services given by the Association of American Physicians and Surgeons in no way duplicate or attempt to supplant the activities of other ethical medical associations, and

WHEREAS, the Association of American Physicians and Surgeons doubles in strength the profession's protection against federal regimentation and in no way can cause disunity within the profession because eligibility for membership in the American Medical Association is prerequisite to membership in AAPS, and

WHEREAS, approval of the principles and objectives of the Association of American Physicians and Surgeons in no way commits a physician to membership inasmuch as membership in AAPS is dependent entirely on the voluntary decision of each physician.

THEREFORE BE IT RESOLVED, that the Council of the Indiana State Medical Association assembled this 26th day of April 1952 at Indianapolis, Indiana, approves the principles and objectives of the Association of American Physicians and Surgeons.



3. **Increased coverage by Blue Shield.** The executive secretary read the Gibson county resolution which is to be presented to the House of Delegates. (See page 537.) At the request of the chairman, Doctor Portteus explained that the decision of the Board of Directors of Blue Shield to offer home and office visits to certain communities on a pilot study plan was prompted with the idea of getting some actuarial background and data on this type of coverage, increasing the services of Blue Shield to the public, and of doing something for the general practitioner. "The idea in itself is not new, in view of the fact that both the A.M.A. and General Practice group have gone on record as favoring such coverage. It is being written by commercial companies. . . . The company in Gibson county accepted the contract which we drew up because it offered them an opportunity to get a wage increase for its employees without going through the Wage Stabilization Board. The Gibson County Medical Society objected very strenuously to the fact that we had offered this contract to this company. Mr. Saylor, Doctor Kahler, and Mr. Stump went to Princeton and tried to explain to the doctors what we were trying to do. They assured us that they were not in favor of it and that they were going to introduce this resolution."

Doctor Garner said the doctors in his part of the state are for the insurance company and against the resolution.

Doctor Clarke expressed the feelings that if Blue Shield is going into a limited territory the cooperation of the local doctors should be sought in advance.

Drs. Dodds, Blazey, Kahler, Howard and Crimm further discussed the subject, as a matter of information to the Council.

#### 4. Matters referred to Council by Executive Committee:

a. *Indiana Student A.M.A.* On motion of Drs. Geider and Blazey the Council is to recommend to the House of Delegates that representatives of the Indiana Chapter of the Student AMA be invited to sit in as observers on reference committee hearings and other committee meetings of the association; also, that some sort of liaison be established between the association and the Indiana Chapter of Student A.M.A. and other organizations whereby arrangements could be cleared through the headquarters office for establishing externships in hospitals and preceptorships during the junior and senior years—this to be done in consultation and with the approval of the Medical School.

b. *Apportionment of delegates.* On motion of Drs. Geider and Combs the Council is to recommend to the House of Delegates that apportionment of delegates be made as of December first of each year rather than as of August first as now provided in the By-laws, and that delegates elected on December first shall serve for one full year.

c. *Federal aid to education.* On motion of Drs. Garner and Geider, the Council approved the preparation of a letter similar to that written by the Indianapolis Medical Society, to be sent to all P-TA presidents in the state, opposing any legislation which would approve the expenditure of federal funds for aid to education.

d. *Employment of field secretary.* Robert J. Amick, Scottsburg, employed as field secretary, beginning April 1, 1952.

5. **Red Cross blood banks.** For the information of the Council Doctor Larson reported on the activities of the Red Cross in LaPorte county in regard to civilian blood banks. Two agreements—(1) that the Red Cross would not go into any community where there was a civilian blood bank, and (2) that the Red Cross would not release any publicity regarding civilian blood banks without first clearing such publicity with the local county medical society,—have been violated. "This is the old idea of getting something for nothing; another step down the road toward socialism."

6. **Summer meeting of Council.** By consent, the next meeting of the Council will be held on Sunday, July 27, 1952.

There being no further business, the meeting was adjourned.

#### Executive Session

At the request of Doctor Olson, the Council went into executive session.

#### THE COUNCIL

April 27, 1952

The Council met immediately after adjournment of the House of Delegates on Sunday, April 27, 1952, in the Assembly Room of the Claypool Hotel, Indianapolis, with eight councilors, one alternate councilor, the president, the president-elect and the executive secretary present. Dr. Wemple Dodds, chairman, presided.

#### Indiana Medical Education Foundation

It was taken by consent that approval of the policies to be followed in establishing the Indiana Medical Education Foundation would be done by mail.

No further business appearing, the Council adjourned.

#### HOUSE OF DELEGATES

April 27, 1952

#### (Interim Session)

The House of Delegates convened for its interim session in the Assembly Room, Claypool Hotel, Indianapolis, at 10:10 a.m., Sunday, April 27, 1952, with the president, Dr. J. William Wright, Indianapolis, presiding.

On motion of Drs. Lester D. Bibler and George R. Daniels, attendance slips signed by the delegates, showing 94 delegates, 11 councilors, 7 past

presidents, the president, and the president-elect present, were accepted in lieu of a roll call. In addition, the editor and associate editor of THE JOURNAL, two Executive Committee members, the chairman of the Committee on Physician-Hospital Relationship, the attorney for the association, the president of the Vanderburgh County Medical Society, one county society alternate delegate, three county society executive secretaries, and the president and two representatives of the Indiana Student A.M.A. were in attendance.

Dr. O. T. Scamahorn, member of Reference Committee on Credentials, announced that a quorum was present, and the chairman declared the House open and ready for the transaction of business.

**THE CHAIRMAN:** According to Chapter XVI, Section 1, of the By-laws, the By-laws may be amended at any annual convention by a *majority vote of all delegates present at that convention*, after the amendment has laid on the table for one day.

The House of Delegates may amend any article of the Constitution by a *two-thirds vote of the delegates present at any annual convention*, provided that such amendment shall have been presented in open meeting at the previous annual convention and that it shall have been published twice during the year in THE JOURNAL of this association.

(On motion of Drs. M. B. Catlett and S. T. Miller, reading of the minutes of the meetings of October 29 and 31, 1951, was dispensed with as these minutes were printed in the December, 1951, JOURNAL.)

#### Election of A.M.A. Alternate Delegate

**THE CHAIRMAN:** Dr. Robert H. Rang, Washington, who was elected alternate delegate at the October 31, 1951, meeting of the House of Delegates, has been declared by the A.M.A. as ineligible to serve for the June A.M.A. session, as he has not been a Fellow of the A.M.A. for the past two years. (Dr. A. G. Blazey moved that Doctor Rang be retained as alternate delegate to the A.M.A. inasmuch as (1) Dr. F. S. Crockett, delegate, will attend the Chicago meeting; (2) Had the interim meeting of the Indiana House of Delegates not been called, Doctor Rang would have maintained this status, and (3) The A.M.A. expects to change its By-laws at the Chicago meeting, eliminating Fellowship, which would make Doctor Rang eligible as alternate delegate. Inasmuch as Indiana will not be deprived of any representation at the June A.M.A. meeting, Dr. Elton R. Clarke seconded this motion, which was carried.)

#### Reference Committees

**THE CHAIRMAN:** In accordance with Chapter X, Section 1, of the By-laws, I have appointed the following reference committees, to serve during this

interim session only. As I read the names, will the members of these reference committees please stand?

##### 1. Sections and Section Work:

Richard P. Good, Kokomo (Howard), chairman  
Clay A. Ball, Muncie (Delaware-Blackford)  
Truman E. Caylor, Bluffton (Wells)  
E. B. Jewell, Logansport (Cass)  
G. M. Nie, Huntington (Huntington)

##### 2. Rules and Order of Business:

Joel T. Carney, Jeffersonville (Clark), chairman  
L. F. Beggs, Columbus (Bartholomew-Brown)  
A. E. Stinson, Rochester (Fulton)  
W. G. Pippenger, Brook (Jasper-Newton)  
John Woner, Linton (Greene)

##### 3. Medical Education and Hospitals:

Elmer C. Singer, Fort Wayne (Allen), chairman  
James W. Denny, Indianapolis (Marion)  
D. D. Stiver, South Bend (St. Joseph)  
Floyd S. Napper, Scottsburg (Scott)  
William C. Wright, Fort Wayne (Allen)

##### 4. Public Policy and Legislation:

Ralph Everly, Indianapolis (Marion), chairman  
Guy E. Ingwell, Knox (Starke)  
Paul A. Garber, South Whitley (Whitley)  
I. E. Huckleberry, Salem (Washington)  
Arthur J. Steffen, Wabash (Wabash)

##### 5. Publicity:

G. B. Wilder, Anderson (Madison), chairman  
N. A. Hibner, Monticello (White)  
Hubert T. Goodman, Terre Haute (Vigo)  
W. M. Stout, New Castle (Henry)  
Paul Arbogast, Vincennes (Knox)

##### 6. Hygiene and Public Health:

Minor Miller, Evansville (Vanderburgh), chairman  
J. M. Kirtley, Crawfordsville (Montgomery)  
Paul R. Tindall, Shelbyville (Shelby)  
Jack Shields, Brownstown (Jackson)  
Robert O. Zink, Madison (Jefferson)

##### 7. Amendments to Constitution and By-Laws:

Alfred Ellison, South Bend (St. Joseph), chairman  
Harry P. Ross, Richmond (Wayne-Union)  
Claude S. Black, Warren (Huntington)  
S. D. Malouf, Peru (Miami)  
Clifford H. Jinks, Indianapolis (Marion)

##### 8. Reports of Officers:

W. R. Troutwine, Crown Point (Lake), chairman  
Max Adams, Flora (Carroll)  
Bernard D. Rosenak, Indianapolis (Marion)  
G. O. Larson, LaPorte (LaPorte)  
Donald M. Kerr, Bedford (Lawrence)

##### 9. Committee on Credentials:

William E. Amy, Corydon (Harrison-Crawford), chairman  
O. A. Province, Franklin (Johnson)  
Lester Hoyt, Indianapolis (Marion)  
O. T. Scamahorn, Pittsboro (Hendricks)  
E. Winton Thomas, Warsaw (Kosciusko)

##### 10. Committee on Miscellaneous Business:

John M. Paris, New Albany (Floyd), chairman  
S. T. Miller, Elkhart (Elkhart)  
J. L. Allen, Greenfield (Hancock)  
Earl W. Mericle, Indianapolis (Marion)  
Oran E. Kay, Spencer (Owen-Monroe)

##### 11. Committee on Prepaid Medical Insurance:

Maurice V. Kahler, Indianapolis (Marion), chairman  
William C. Reed, Bloomington (Owen-Monroe)  
C. F. Briggs, Sullivan (Sullivan)  
A. E. Stouder, Kempton (Tipton)  
F. R. N. Carter, South Bend (St. Joseph)



### Reports of Officers

The president and president-elect reported that everything was progressing smoothly.

The EXECUTIVE SECRETARY presented the following report:

The president has asked me to report to the House on the operation of your association, and that the report should be detailed sufficiently to afford the House an opportunity to have knowledge of the operation of the headquarters office.

In view of this request, I have prepared a rather detailed report. I shall attempt to make it as brief as possible and not bore you with many small details; however, it is detailed in certain respects.

Since the first of the year, the headquarters office has been kept busy with the many normal and everyday duties. The staff has functioned diligently and faithfully, and have been cooperative at all times. Without their cooperation your executive secretary would have found the work much more difficult. At present your staff is comprised of three girls in the headquarters office, two in THE JOURNAL office, one field secretary and your executive secretary.

In an effort to give you some idea of the activities of your headquarters office, perhaps the following will in some way explain the routine work.

Since January 1, 22,088 pieces of mail have gone out of the office as of April 26. This figure includes the News Flash, but does not take into consideration parcel post shipments, THE JOURNAL, nor the multiple enclosures included in many of the letters.

Your executive secretary has attended 72 meetings of various types since the first of the year and filled 4 speaking engagements.

Your office has handled the receipt of 569 contributions and six contributions from organizations for the Medical Education Foundation Fund, having received in cash as of April 26 more than \$32,487.77, which has been forwarded to the National Fund.

You will note that our membership has been prompt in sending in their dues so far this year.

Number of members March 26, 1952	-----	3,327*
Number of members March 26, 1951	----	3,156
Gain over last year	-----	171
Number of members December 31, 1951	----	3,694
*Includes 66 in military service (gratis)		

81—\$10.00 members (residents and interns)

250 senior members

27 members, dues remitted by Council

Number who have paid A.M.A. dues:

1950	-----	2,900;	1951	----	2,918;	1952	----	3,001
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The collection of the A.M.A. dues and the many details attached thereto has increased the work load tremendously during the past few months. I am sure I am right in saying that the detail work on this phase has doubled our clerical load.

I have been in conference with officials of the American Medical Association, and reviewed with them many of the problems connected with the A.M.A. dues structure. As a result, the Board of Trustees authorized the A.M.A. office to work out satisfactory plans with the various states, and I believe that I can report that Indiana is well on the way toward solving many of the problems which have made the detail work load so heavy.

While we are talking about dues, the Executive Committee has approved a new type of dues collecting procedure which it is believed will greatly simplify and streamline our dues-collecting procedure. The greatest benefit should be to the busy physician who is also trying to do a good job of being secretary to his county society.

In the past it has been necessary for the county secretary to fill out two separate receipts in detail form, doing considerable writing in each. The new form will be a four-part, snap-out form, designed to fit both our and the A.M.A. files. The secretary will be sent a complete receipt for each member of his society, already addressed with the physician's name, address and city. Upon receiving these the secretary will merely date the form, showing the day the dues were paid, make two or three check marks designating what the payment covers, add the amount of the county dues, show the total amount received, sign his name, tear off two of the forms, giving one to the member and retaining one for the society files, and sending the other two copies to the headquarters office with the dues payments. In the headquarters office, we will separate the two, filing one in our regular membership files, and forwarding the other to the A.M.A. with the remission of our members' A.M.A. dues. At the same time the membership card will be revised to eliminate hours of typing in the office. These when rearranged will require only numbering and dating before being sent to the member.

### COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

This committee has been most active since the first of the year; as each of you know they have been conducting the campaign to raise \$100,000.00 for our nation's medical schools. They have made an effort to be in a position to make a complete report on this effort before the House of Delegates of the A.M.A. in June. I might say at this point, however, that for the second time in the past three years Indiana has become recognized as a leader, being first in the nation in the amount turned in this year for our medical schools.

The postgraduate education program being carried on by this committee is attaining new importance; not only have the telephone seminars continued to be accepted, but more counties are using recordings this year than ever before and the reception of this service has been amazing. Texas and Kentucky have adopted this system and New

York State and Hawaii are planning on making use of the telephone to contact their societies.

To broaden the service in this field the committee has instituted the development of a loan library for use of county medical societies or individual physicians. As of today we have recorded 27 hours of scientific lectures by eminent authorities from throughout the United States.

#### COMMITTEE ON RURAL HEALTH

The Committee on Rural Health has been actively engaged in preparing a physician placement service and will soon be prepared to really begin work toward assisting communities in need of a physician and prospective physicians being brought into contact with each other. I might add in this that the A.M.A. has seen copies of the material and the system to be used and have asked that we supply them with the material, as they would like to consider its application and adoption for a nation-wide system.

This year for the first time, the committee solicited and received the assistance of the Woman's Auxiliary. Two rural health conferences for women are being conducted in addition to the state-wide rural health conference held annually at Purdue University. The first of these women's meetings was held in the Lancaster Township School in Wells County on March 27. The registered attendance for this meeting was 525. The second conference will be held on the campus of Indiana University in Bloomington on May 21.

The Board of Appeals has worked hard in formulating their operating policies. As of this date, twelve cases have come before the Board and six of them have been closed. The balance are in process of being settled.

The Rural Health Committee has also completed holding five regional meetings throughout the state, and have embraced every county society in these meetings. I want to report that the president has devoted his time to attendance at each of these meetings and has contributed much toward bringing about a better understanding between our membership and the association program. Other officers have attended these meetings and it is the feeling that much good has been accomplished.

#### OTHER COMMITTEES

If time permitted, I would like to review for you some of the activities of the other committees of the Association. On the whole they are fairly active, and many are in the process of or have developed some very worth-while programs. (Activities of the Committees on Industrial Health, Public Relations, and Public Policy and Legislation reviewed briefly.)

It seems that our problem in the past has been our seeming inability to bring about an understanding between the membership and our societies

as to just what our various committees are doing, and just what their programs call for. This has been a bottleneck in making many of our programs as effective as they should be. We hope that a partial solution is being brought about through these regional meetings and through our field service.

DR. WEMPLE DODDS, the chairman of the Council, presented the following matters:

1. Resolution from Porter county, passed at the October 31, 1951, meeting of the House of Delegates, and referred back to the House for reconsideration:

*Be it resolved*, That the Indiana State Medical Association sponsor a bill before the General Assembly of Indiana, that would make the Chief of Staff, who is elected annually by the hospital staff, a regular or legal fifth member of the hospital's Board of Governors.

(Referred to Reference Committee on Medical Education and Hospitals.)

2. Recommendation of the Council that representatives of the Indiana Chapter of the Student A.M.A. be invited to sit in as observers on reference committee hearings and other committee meetings of the association, and that some sort of liaison be established between the association and the Indiana Chapter of Student A.M.A. and other organizations whereby arrangements could be cleared through the headquarters office for establishing externships in hospitals and preceptorships during the junior and senior years.

On motion of Drs. Daniels and Nafe the House voted to extend an invitation to representatives of the Indiana Chapter of Student A.M.A. to sit in the meetings of the House of Delegates.

3. Recommendation of the Council that the By-laws be changed, making December first rather than August first the date on which to apportion delegates to the Indiana State Medical Association and that delegates elected on December first shall serve for one full year. (Referred to Reference Committee on Amendments to Constitution and By-laws.)

#### Reports of Special Committees

1. DR. W. H. LANE, chairman of the Committee on Physician-Hospital Relationships, presented the following report, which was referred to the Reference Committee on Prepaid Medical Insurance:

We wish to bring to the attention of the House of Delegates of the Indiana State Medical Association that your committee feels that it is important that the professional services of anesthesiology, pathology and radiology must be divorced from potential control by the hospital. The longer these services are covered by Blue Cross, the greater is the danger that they will be regarded as usual and customary hospital services.

We want to be sure that the difference between Blue Shield and Blue Cross are fully understood.



As companion agencies, and because cooperation between them is absolutely necessary in order to insure their members adequately we feel that they should both adhere to insuring services in their respective fields. This would do much to dispel the confusion regarding the difference between these two agencies.

Blue Cross insurance covers hospital services, billed to the patient by the hospital. Blue Shield insurance covers professional services. It pays the patient, who in turn pays the doctor or assigns to Blue Shield the right to pay the doctor directly. Under Blue Shield the doctor is directly responsible to the patient for providing adequate care. If professional anesthesia, for instance, is covered by Blue Cross, it becomes a hospital service; the anesthesiologist is forced to surrender his direct personal responsibility to the patient and is often reduced to the status of a technician with an M.D. degree. He is under lay control and may be asked to do what is best for the hospital which may not coincide with what is best for the patient.

We think that you should be cognizant of the fact that the American Hospital Association has a Blue Cross Commission acting as a coordinator of all Blue Cross Plans. In articles published in both American Hospital Association Journals "Hospitals" and "Trustee" (which is published for the governing boards of Hospitals) it is stated that "for several years, hospital administrators, hospital trustees and Blue Cross executives and Blue Cross trustees have been disturbed about the recklessness with which medical staff members lavish expensive medications and expensive "hospital services" on patients who happen to be receiving Blue Cross benefits. This is disturbing because such extravagance has been a large factor in raising the cost of Blue Cross coverage, because carried far enough it could destroy Blue Cross, and especially because the problem is beyond solution by nonmedical men—except by violating an old and theoretically sound tradition. The tradition, of course, is that a nonmedical person should not presume to tell a physician how he should prescribe for or treat a patient. In deference to this tradition, hospital and Blue Cross representatives have wrung their hands and held their tongues."

It will become obvious to anyone who reads the American Hospital Association Journals that there are many within their ranks whose aim is the eventual control of the practice of medicine through the hospital. In the March 1951 issue of "Hospitals," Dr. Wilinsky, the president of the American Hospital Association, in a quotation from a speech he had made before the annual meeting of the Massachusetts Hospital Association stated: "I was bold enough to envision a greater understanding in the future on the part of the American people to the all-important part the hospital will play as the citadel of health and as a background in which the medical profession, and

all who work with it, will function most efficiently and for the good of all."

Among their aims is the intent to promote the hospital as a community health center by providing diagnostic and therapeutic services, the development of out-patient services with full time medical coverage on contract or salary basis, and exploration of group practice as a method of staff organization.

The implications extant in allowing the piecemeal incorporation of the different fields of the practice of medicine into the organizational structure of the hospital must be obvious to everyone.

In an address before the American Hospital Association in September 1951, the president of the American Medical Association, Dr. John W. Cline, stated when such services as anesthesiology and radiology and pathology or physical medicine are performed by physicians they constitute the practice of medicine. In many states when they are performed by others, these acts constitute violations of law.

It was his view that where Blue Cross and Blue Shield work on a cooperative basis (as in Indiana) Blue Shield should write the coverage for these medical services. Where the two compete the Blue Cross plans can indemnify the physician for these services unless he requests them to do otherwise.

The phrase relative to payment for services "if administered by an employee of the hospital" should be deleted. It leads to confusion on the part of the hospital, the physician and the patient, and causes unnecessary irritation.

Your committee proposes that the House of Delegates ask the Board of Directors of Mutual Medical Insurance for a more vigorous effort toward fulfilling the resolutions made previously concerning Blue Shield coverage of professional services; and, a bi-annual report on their progress in fulfilling the recommendations made to them regarding the insurance coverage of these medical services.

Further, this committee wishes to recommend that Mutual Medical Insurance provide hospital (nonsurgical) medical care in all future Blue Shield policies and that negotiations be started to arrive at a proper and reasonable fee schedule.

W. H. LANE, M.D., *Chairman*  
M. V. KAHLER, M.D.  
L. D. BIBLER, M.D.  
HARRY PANDOLFO, M.D.  
W. C. WRIGHT, M.D.  
R. W. LAVENGOD, M.D.

2. DR. W. H. GARNER, chairman of the Committee on Veterans Affairs and Rehabilitation, presented the following report, which was referred to the Reference Committee on Prepaid Medical Insurance:

Your Committee on Veterans Affairs and Rehabilitation met on April 6, 1952, to consider the following resolution which was referred to it by the House of Delegates:

WHEREAS, Veterans Hospitals are accepting non-service-connected disability cases among veterans; and the acceptance of such cases indicates the developing of a policy among Veterans Hospitals of accepting hospital benefits paid by commercial insurance companies and thereby enlarging the activities of such hospitals beyond the purpose for which they were built, which might result in the overcrowding of veteran's facilities to the disadvantage of veterans suffering from service-connected disabilities; and,

WHEREAS, the use of Veterans Hospitals and other government facilities for the treatment of veterans suffering from nonservice-connected disabilities would tend to reduce the public patronage of local nongovernment hospitals and medical facilities to the general disadvantage of the public at large; and,

WHEREAS, this practice would introduce unfair competition of such government agencies with the local agencies, and if permitted to develop widely would produce a result detrimental locally and nationally to both the government and the nongovernment agencies.

Therefore, Be It Resolved, That the House of Delegates of the Indiana State Medical Association strongly disapprove of this procedure on the part of Veterans Hospitals.

Be It Further Resolved, That a copy of this resolution be sent to each Representative and Senator of Indiana, the Veterans Administration National Offices, American Hospital Association, American Medical Association, each State Medical Society, and the Indiana Association of Insurance Underwriters.

Your committee sees no objection to this resolution and recommends its adoption by the House of Delegates.

### New Business

#### Resolutions Referred to the Reference Committee on Medical Education and Hospitals

##### 1. DR. KEMPER VENIS, Muncie: *Resolution concerning utilization of facilities for graduate and postgraduate medical education in Indiana:*

WHEREAS: there are in the State of Indiana many medical educational institutions which have available for teaching purposes outstanding material, facilities, and instructors of ability and note, and

WHEREAS: it is desirable for such facilities, material, and instructors to be made available to the largest number of students, and

WHEREAS: the place of the United States in the broad field of world medicine is one of outstanding preeminence, and

WHEREAS: it is desirable that the educational facilities of the United States be made available for postgraduate students of medicine, not only for our own citizens, but, for those of other nations, whose medical educational facilities fail to provide the high standards of training found in the United States, and

WHEREAS: Indiana, because of its outstanding position in the field of medical education can, and, should participate in the utilization of its facilities on a world-wide basis, and

WHEREAS: such participation has been denied in Indiana to many students from other countries because

of the requirement that a license to practice medicine must be obtained by examination before a student may undertake graduate or postgraduate medical education in Indiana, and,

WHEREAS: it is within the power of the State Board of Registration and Examination of Indiana to grant temporary licenses to qualified graduate or postgraduate students of medicine in Indiana.

Therefore, Be It Resolved that the Members and Officers of the Indiana State Medical Association request the State Board of Medical Registration and Examination to grant temporary licenses for the practice of Medicine to qualified students of medicine for graduate or postgraduate study in acceptable medical educational institutions in the State of Indiana.

DELAWARE COUNTY DELEGATES

##### 2. DR. JAMES W. DENNY, Indianapolis: *Resolution to refer the Matter of establishing Indiana Medical Education Foundation to the Executive Committee:*

WHEREAS, a form of resolution for establishing the Indiana Medical Education Foundation and of the terms and conditions under which funds and property would be acquired and used in the said Foundation has been submitted in draft form to the House of Delegates for their consideration; and,

WHEREAS, details with regard to the entire plan must be worked out to the satisfaction of this Association, of Indiana University Medical School, and of the American Medical Education Foundation, and this may require some changes in the draft submitted and will require conferences between representatives of the said three institutions,

Therefore, Be It Resolved That the Indiana State Medical Association approves in principle the draft of the resolution establishing Indiana Medical Education Foundation, which has been presented to the House of Delegates and refers the matter of arriving at a final form of statement of the said resolution to the Executive Committee of the Indiana State Medical Association with power of final action in regard thereto, including power to make such changes in the details of the said resolution as may be necessary to meet the approval of the American Medical Education Foundation and the Board of Trustees of the Indiana University School of Medicine, and give final approval to the resolution in the form agreed upon, without essentially changing the purpose as expressed in the draft of the resolution submitted to the House of Delegates.

#### Resolution Referred to the Reference Committee on Public Policy and Legislation

##### 1. *Resolution on nonservice-connected disability in the Veterans facilities, read by the executive secretary:*

WHEREAS, The hospital and medical care of the veteran with service-connected disability or disease and the care of the medically indigent veteran with nonservice-connected disability or disease is and should be the just concern of the public and the medical profession; and

WHEREAS, The free care of the veteran with nonservice-connected disability or disease who can pay for his hospitalization and medical care is contrary to our traditional system of government and is an unwarranted burden on the taxpayer and threatens the quality of care to the deserving veteran by overloading the professional services of Veterans Hospitals; and

WHEREAS, The Association of American Medical Colleges at its 195th annual meeting called attention to this abuse in relation to so-called Dean's Hospitals and



recommended that the medical schools concerned ascertain the extent of this abuse and the reasons for it and take steps to correct it;

Therefore, *Be It Resolved* that this House of Delegates (Tennessee) strongly commends and supports the action of the Association of American Medical Colleges and directs the Executive Secretary of this Association (Tennessee) to inform the other state medical Associations of this action, and furthermore, that the House goes on record as requesting its delegates to the American Medical Association to further the action of the Association of American Medical Colleges in every way possible.

#### Resolutions Referred to the Reference Committee on Amendments to the Constitution and By-Laws

##### 1. DR. M. B. CATLETT, Fort Wayne: *Resolution to make Eligibility to Senior Membership Seventy instead of Seventy-five Years:*

In accordance with a resolution passed by the Fort Wayne Medical Society on December 18, 1951, to-wit: "That this Society go on record as favoring the lowering of the age of Senior membership from 75 to 70, in accordance with A.M.A. policy, and that such members no longer pay local or state dues, this to go into effect automatically the same year that the doctor attains age 70, and that furthermore our delegates be informed of these wishes and be instructed to re-open the question at the Interim Session, and at the District meeting." We are notifying you of this our desire and intent, as required by a recent ruling of the State Association.

We beg diligent study of this question and solicit your support in the coming session if it is deemed by your Society wise and a proper thing to do.

M. B. Catlett, M.D., *Chairman*

B. M. Edlavitch, M.D.

Mahlon F. Miller, M.D.

##### 2. DR. CLEON A. NAFE, Indianapolis: *Amendment to Constitution regarding Senior Membership:*

*Resolved*, That Section 4 of Article IV of the Constitution be amended to read as follows:

Sec. 4. Senior Members. Senior members shall be physicians of the State of Indiana who have attained the age of seventy-five years and have held membership in the Indiana State Medical Association for twenty years or more; or who have held membership in the Indiana State Medical Association and in some one or more other like state organization which is a component state organization of the American Medical Association, for a combined total of twenty years or more, and who, upon their application, have been certified to the executive secretary as eligible for such membership by their county societies of which they are members. It shall be the duty of the county medical society to verify, through the office or offices of any other such state organization or organizations, the fact of membership therein when such membership is claimed as part compliance with the eligibility requirement of twenty years of membership.

All members who, previous to the adoption of this amendment to the constitution, were certified as honorary members on the basis of the above qualifications, shall hereafter be classified as senior members.

#### Resolutions Referred to the Reference Committee on Miscellaneous Business

##### 1. DR. RALPH C. EADES, Valparaiso: *Resolution from the Porter County Medical Society on Dr. Fred L. Adair:*

*Be It Resolved* That Fred L. Adair, M.D., now a member of the Porter County Medical Society, but living in retirement at Maitland, Florida, be made an Honorary member of the Indiana State Medical Association.

##### 2. DR. R. W. VAN BOKKELEN, Mooresville: *Reso-*

##### *lution from the Morgan County Medical Society regarding meeting place of state association:*

It is the opinion of the component members of the Morgan County Medical Society that

WHEREAS it has been the custom to hold the state meeting either in Indianapolis or French Lick for the past several years, and

WHEREAS attendance is declining, and the enthusiasm of those attending has been generally declining, and

WHEREAS a convention in Indianapolis renders it virtually impossible for a great bulk of those members attending from Central Indiana to get away from their practices enough to attend the meeting more than part time, and

WHEREAS a convention in French Lick offers limited recreational and entertainment facilities for those attending, and

WHEREAS there are other component county societies who would welcome acting as host for the state convention, now therefore

*Be it resolved* that the annual state meeting of the Indiana State Medical Association shall be held elsewhere than Indianapolis or French Lick at least once every five years, and also

*Be it further resolved* that if no other location with satisfactory facilities for the meeting can be arranged within the confines of Indiana, that it will be agreeable to hold meetings in neighboring cities, not too far distant, which may have adequate facilities, such arrangements being made as might be necessary that there shall be no conflict with the constitution rules and by-laws of the Indiana State Medical Association for holding a state meeting outside the state of Indiana.

##### 3. DR. CLEON A. NAFE, Indianapolis: *Resolution on Indiana Student A.M.A.:*

WHEREAS it is desirable that the S.A.M.A. Chapter of Indiana University has a close liaison with the Indiana State Medical Association,

Therefore, *Be It Resolved*, That this House of Delegates invite that organization to send three representatives as delegates, without power to vote, to each House of Delegates meeting of the State Medical Association.

#### Resolutions Referred to the Reference Committee on Prepaid Medical Insurance

##### 1. DR. JOHN K. FOLCK, Princeton: *Resolution from the Gibson County Medical Society regarding Blue Shield:*

1. WHEREAS, the people of this country are traveling down the road toward a complete Welfare State at a very rapid pace.

2. WHEREAS, Socialism is creeping upon us from all directions and oftentimes under the guise of benefiting our profession.

3. WHEREAS, Voluntary Health Insurance has been accepted by the profession as a logical means of combating the inroads of Socialism.

4. WHEREAS, our own State Medical Association, recognizing this program, has authorized the formation of a Corporation known as The Mutual Medical Insurance Company or Indiana Blue Shield.

5. WHEREAS, this Company operating the so-called "Doctor's Plan" has provided a satisfactory voluntary insurance plan for the prepayment of the greater part of the more expensive medical care and has gained national recognition.

6. WHEREAS, the Directors of our own plan have embarked on a new proposal to provide coverage for home and office calls.

7. WHEREAS, such similar plans such as formerly provided for on a limited scale by the Miner's Welfare and

Retirement Fund have met with financial disaster and ultimate failure.

8. WHEREAS, It places an undue burden on the physician to be his own policeman and at the same time assume an unpredictable amount of clerical work.

9. WHEREAS, Even a modest success of the venture would only result in increased demands for unwarranted services by the Socializers and failure of the plan would prove to them that Voluntary health plans were inadequate.

10. WHEREAS, Failure of voluntary plans would then make the demand for Compulsory Political Health Insurance more pressing and Government Control seem the only solution.

*Be It Therefore Resolved:* That the House of Delegates recommend to instruct the Directors of Blue Shield to withhold further types of coverage than those in force at the present time until adequate research and study has been made by the Committee on prepaid health insurance before the "Doctor's Plan" defeats its own purpose.

GIBSON COUNTY MEDICAL SOCIETY,  
E. V. Marchand, M.D., *President*.  
R. E. Weitzel, M.D., *Secretary*.

Dated at Princeton, Indiana, this 10th day of March, 1952.

2. DR. MAURICE V. KAHLER, Indianapolis: *Resolutions adopted by the Permanent Study Committee on Medical Care Insurance:*

(1) *Resolved:* That the Permanent Study Committee on Medical Care Insurance recommend that the Insurance Companies, offering the public hospital, surgical and medical insurance, recognize that an assistant's fee and surgeon's fee should be incorporated on their claim banks, the sum total of which shall not exceed the total amount of the indemnity for which the applicant is indemnified and that each be paid by a separate check.

(2) By unanimous vote the following motion was adopted and it was recommended to the House of Delegates for approval at the Interim meeting on April 27, 1952:

Moved, to approve the action of the House of Delegates of the American Medical Association in approving medically sponsored plans preparing a contract for the purpose of providing coverage to dependents of Armed Forces personnel, as adopted at the December, 1951, meeting in Los Angeles and known as the Navy resolution.

The Navy resolution, as adopted by the A.M.A. House of Delegates, is as follows:

*Resolved,* That if the independent judgment of the Department of Defense or Congress the welfare of our preparedness program requires that dependents of members of our Armed Forces receive medical care on a service basis, then the medical profession stands ready to provide such service through Blue Shield and other medical society sponsored plans.

3. DR. LESTER D. BIBLER, Indianapolis: *Resolution on Blue Shield:*

WHEREAS, commercial insurance carriers are developing insurance policies to meet the public demand, without consulting the medical profession, and

WHEREAS, the Indiana Blue Shield plan was organized and is sponsored by the Indiana State Medical Association, and

WHEREAS, the Board of Directors of Blue Shield is composed of physicians, nominated by the Council of the Indiana State Medical Association, now therefore,

*Be It Resolved* that this body hereby expresses its complete confidence in our professional colleagues to

conduct the Indiana Blue Shield Plan in the best interest of our patients and our profession, and

*Be It Further Resolved* that in expressing this confidence we also request our representatives, the Board of Directors of Blue Shield, to take any steps necessary to enable Blue Shield to more adequately provide for the needs of the people if in their judgment any extension of services are deemed necessary, keeping in mind at all times the interest of the patient and physician so that our present patient-physician relationship will not be disturbed by government agencies attempting to do something we as physicians are not willing to do ourselves.

4. DR. HUBERT T. GOODMAN, Terre Haute: *Resolution passed by the Vigo County Medical Society at its regular meeting, April 9, 1952:*

*Be It Resolved* That the Indiana State Medical Association recommends and advises that all physicians' charges for Pathology, Roentgenology or Anesthesiology, regardless of whether they be charges submitted by the hospital or the individual physician, be assumed by Blue Shield instead of Blue Cross."

### Afternoon Session

Following luncheon in the Chateau Room of the Claypool Hotel, the House reconvened at 2:00 p.m. in the Assembly Room. Doctor Scamahorn announced that a quorum was present and the chairman declared the session continued.

### Election of Dr. Robert H. Rang as Alternate Delegate to the A.M.A.

On motion of Drs. Wemple Dodds and Gordon Thomas, Dr. Robert H. Rang of Washington was elected to the office of alternate delegate to the A.M.A. (alternate to Dr. F. S. Crockett, Lafayette), subject to the approval of the American Medical Association at its June, 1952, meeting.

### Abolishment of AMA Fellowship

On motion of Drs. Minor Miller and Ralph C. Eades, the House instructed the delegates to the A.M.A. to vote for the abolishment of the Fellowship status in the American Medical Association. Dr. F. S. Crockett, A.M.A. delegate, explained that the idea is not so much to abolish the Fellowship but to have one classification of membership.

### Reports of Reference Committees

#### MEDICAL EDUCATION AND HOSPITALS

DR. ELMER C. SINGER, chairman, presented the following report, which was adopted section by section and as a whole, as noted:

Your Reference Committee on Medical Education and Hospitals commends the standing committee on Medical Education and Hospitals for its continued interest and work on this program. Especially do we wish to call attention again to the House of Delegates relative to the untiring efforts of Dr. J. W. Denny and his committee for assuming leadership for the nation thus far in 1952 in assisting our medical schools by leading all other states in contributions.

Your committee spent no little time and thought on the following resolution:



*Be It Resolved*, That the Indiana State Medical Association sponsor a bill before the General Assembly of Indiana, that would make the Chief of Staff, who is elected annually by the hospital staff, a regular or legal fifth member of the hospital's Board of Governors.

1. The Council of the Indiana State Medical Association referred the above resolution back to the House of Delegates for discussion with the expression that such legislation in their opinion would not be in the best interest of the medical profession.
2. And further, it was brought out in discussing this subject by the Reference Committee that (1) the medical staff of such hospital must share the responsibility in case of any disagreement on policy management, even though represented by only one vote in opposition to the other four members of the Board and (2) that proper liaison with the organized medical staff and the Board of Governors of the hospital would work more satisfactorily.

This committee concurs with the above ideas and recommends that the resolution be not adopted. Therefore we suggest that the action taken by the House of Delegates on October 31, 1951, in which the above resolution was approved be rescinded at this time. (Adopted on motion of Drs. Singer and Joseph L. Allen.)

Relative to the resolution requesting that the members and officers of the Indiana State Medical Association request the State Board of Medical Registration to grant temporary licenses to qualified students for graduate and postgraduate medical education:

While we recognize the intent and purpose of the resolution, it has been suggested by a member of the Medical Registration Board that this resolution would necessitate a complete change in the structure of the Medical Practice Act to effect such legislation.

Therefore the committee proposes that the president appoint a special committee for further study on this subject. (Adopted on motion of Drs. Singer and George R. Daniels.)

In reference to the resolution pertaining to the Indiana Medical Education Foundation as submitted by the Committee on Medical Education and Hospitals, that the Indiana State Medical Association approves in principle the draft of the resolution establishing such a foundation, which has been presented to the House of Delegates, and refers the matter of arriving at a final form to the Executive Committee of the Indiana State Medical Association with power of final action: with this resolution the Committee concurs in the ideas set forth in the above resolution.

ELMER C. SINGER, M.D., *Chairman*  
JAMES W. DENNY, M.D.  
D. D. STIVER, M.D.  
FLOYD S. NAPPER, M.D.  
WILLIAM C. WRIGHT, M.D.

(Dr. Singer moved that this last section be adopted; motion seconded by Dr. Harry P. Ross. Dr. A. P. Hauss moved that the resolution be amended by striking out the words, "Executive Committee" and inserting the word "Council," thereby leaving the final decision to the Council of the state association and not to the Executive Committee. This motion was seconded by Dr. Will Thompson. Discussed by Drs. Denny, C. H. McCaskey, Alfred Ellison and Hauss. Motion to amend the resolution passed on voice vote.)

(Dr. Singer's motion for adoption of the report in its entirety, as amended, was seconded by Dr. George Daniels, and carried.)

### Public Policy and Legislation

DR. RALPH EVERLY, chairman, presented the following report, which was adopted on motion of Doctor Everly, seconded by Dr. Harry P. Ross:

The Committee approves the acceptance of the resolution from the Tennessee State Medical Association dealing with nonservice-connected disability in Veterans facilities.

And further, that each delegate take back to his local medical society an admonition that every physician exercise careful judgment before he places his signature on any form or paper requesting free medical and dental care for veterans within Veteran facilities.

RALPH EVERLY, M.D., *Chairman*  
GUY B. INGWELL, M.D.  
PAUL A. GARBER, M.D.  
I. E. HUCKLEBERRY, M.D.  
ARTHUR J. STEFFEN, M.D.

### Amendments to Constitution and By-Laws

DR. ALFRED ELLISON, chairman, presented the following report, which was adopted section by section, on motion of Doctor Ellison with seconds by those indicated:

The recommendation from the Council that all counties shall determine the number of their delegates to the Indiana State Medical Association based upon the number of members of the respective county societies as of December 1 of each year, is approved by this reference committee. (Motion for adoption seconded by Dr. Harry P. Ross.)

The proposal to amend the Constitution regarding senior membership, as provided in Section 4 of Article IV of the Constitution, is approved by this committee, provided the following wording is inserted after the word "application" in line 9, to wit: "and upon the recommendation of their respective county medical society." (Motion for adoption seconded by Dr. Harry P. Ross.)

The resolution to make eligibility to senior membership seventy instead of seventy-five years is not recommended by your reference committee for two reasons. First, there would be a loss of revenue of almost seven thousand dollars annually in the event of such change. Secondly, because there is pro-

vision now for such a physician to be excused from the payment of his state society dues in the event of hardship. (Motion for adoption seconded by several.)

Your reference committee recommends to the House of Delegates that if the interim sessions are to be continued, we believe the standing committee on Constitution and By-Laws should recommend such revisions of the Constitution and By-Laws as will make the actions of the House of Delegates at such interim sessions effective. Under the present regulations, the actions of the House of Delegates regarding amendments to the Constitution must be acted upon at an annual convention rather than at an interim session and only after the amendment has been presented in open meeting at the previous annual convention rather than interim session. Likewise, amendments to the By-laws must be carried out at an annual convention rather than at an interim session. (Purely a recommendation; no action necessary.)

ALFRED ELLISON, M.D., *Chairman*  
HARRY P. ROSS, M.D.  
CLAUDE S. BLACK, M.D.  
S. D. MALOUF, M.D.  
CLIFFORD H. JINKS, M.D.

(Doctor Ellison's motion for adoption of this report as a whole was seconded unanimously.)

#### Miscellaneous Business

DR. JOHN M. PARIS, chairman, presented the following report, which, with the exception of the second section, was adopted, on motion of Doctor Paris, seconded by those indicated:

(1) Your committee approves the resolution of the Porter County Medical Society regarding honorary membership for Dr. Fred L. Adair. (Motion for adoption of this section seconded by Dr. W. H. Garner.)

(2) Your committee approves the resolution of the Morgan County Medical Society with this change in the wording:

*"Be It Resolved*, that one meeting, as a trial meeting, be held in some nearby city other than Indianapolis or French Lick, and if it can't be held in Indiana, that it be held in Chicago or Cincinnati, or some nearby city."

(Motion for adoption of this section seconded by several. Following discussion by Drs. Ellison, Van-Bokkelen, Maurice Glock, Hauss, McCaskey, Ross, Eades, Denny, and Minor Miller, Doctor Scamahorn's motion to table the original and the amended resolutions was duly seconded and carried.)

(3) Your committee approves the resolution of Doctor Nafe pertaining to the Student A.M.A. (Motion for adoption seconded by Dr. George R. Daniels.)

JOHN M. PARIS, M.D., *Chairman*  
S. T. MILLER, M.D.  
J. L. ALLEN, M.D.  
EARL W. MERICLE, M.D.  
ORAN E. KAY, M.D..

#### Prepaid Medical Insurance

DR. MAURICE V. KAHLER, chairman, presented the following report:

(1) The Reference Committee on Prepaid Medical Insurance approves the resolution presented by the Permanent Study Committee on Medical Care Insurance in which the Permanent Study Committee "recommends that the Insurance Companies, offering the public hospital, surgical and medical insurance, recognize that an assistant's fee and surgeon's fee should be incorporated on their claim blanks, the sum total of which shall not exceed the total amount of the indemnity for which the applicant is indemnified and that each be paid by a separate check." I move the adoption of this section of the report. (Motion duly seconded, and carried.)

(2) Your reference committee recommends that the following resolution, presented by the Permanent Study Committee on Medical Care Insurance this morning, be tabled:

Moved, to approve the action of the House of Delegates of the American Medical Association in approving medically sponsored plans preparing a contract for the purpose of providing coverage to dependents of Armed Forces personnel, as adopted at the December, 1951, meeting in Los Angeles and known as the Novy resolution.

(Motion seconded by Dr. F. R. N. Carter, and carried.)

(3) Your reference committee approves the resolution concerning Veterans' Hospitals, presented by the Committee on Veterans Affairs and Rehabilitation. (Dr. Kahler's motion for adoption of this section of the report duly seconded, and carried.)

(4) The resolution introduced by Doctor Bibler, expressing confidence in the management of Indiana Blue Shield, is approved by this reference committee. (Motion for adoption of this section seconded by several, and carried.)

(5) The committee reports on the report of the Committee on Physician-Hospital Relationships and on the Vigo county resolution as follows:

We commend the committee on its interest and evident study of this problem. We recommend that the subject matter of the report be given further study by the same committee.

Regarding the Vigo county resolution:

(a) The question of Blue Shield coverage for anesthesiology, radiology, pathology and physical medicine is now highly complicated by the wide variety of arrangements between hospitals and physicians.

(b) The problems arising therefrom, it seems to the committee, cannot be solved without further work being done by the physicians in these specialties in an effort at a solution generally satisfactory to these physicians themselves. Until they reach a harmonious solution among themselves, we be-



lieve we cannot lay down any special demands before Blue Shield or Blue Cross in that regard.

(c) However, we recommend that Blue Shield take over the coverage of these services, and that they do it as rapidly as it can be done.

(Doctor Kahler's motion for adoption of this section of the report duly seconded, and carried.)

We now take up separately the Gibson County resolution.

1. Our Committee calls attention to the word "authorized" under the fourth "Whereas" clause, and recommends that the word "authorized" be changed to the words "encouraged and supported"—for the reason that from the beginning of Blue Shield it was the purpose of the Medical Association that Blue Shield should be entirely separate from the Association as a matter of law. Therefore, in resolutions adopted by the House of Delegates dealing with Blue Shield, this complete separation should always be observed. The Committee believes that to use the word "authorized" might suggest the inference that the Association as such might be chargeable with the responsibility for the actions of Blue Shield as such.

2. We recommend that in the seventh "Whereas" clause the word "such" which follows immediately the word "Whereas," be stricken out in the interest of grammatical clarity, and the sentence then be further punctuated by placing a comma after the word "plans" and another comma after the word "Fund."

3. For the same reason as stated regarding Clause 4, this Committee recommends that the language of the resolution itself be revised and amended to read as follows:

*Be It Therefore Resolved* That the House of Delegates hereby recommends to the Board of Directors of Blue Shield that Blue Shield move cautiously in adding any new types of coverage, and refrain from doing so unless convinced by adequate research and study that it is feasible, and that an actual public demand for it exists; and that the House of Delegates further recommends that in connection with such research and study the said Blue Shield Directors confer with the Committee on Prepaid Health Insurance of Indiana State Medical Association and obtain their suggestions and advice.

The Committee further recommends that when the resolution is amended in the manner herein stated that the resolution as amended be approved and adopted.

Mr. President, I move the adoption of this part of our report.

(Motion for adoption of this section duly seconded, and carried.)

MAURICE V. KAHLER, M.D., *Chairman*  
WILLIAM C. REED, M.D.  
C. F. BRIGGS, M.D.  
A. E. STODER, M.D.  
F. R. N. CARTER, M.D.

(Doctor Kahler's motion for adoption of the entire report was seconded by Dr. Lester D. Bibler.)

DR. LESTER D. BIBLER: I would like to offer an amendment to Doctor Kahler's report:

I move that this House of Delegates recommend that the Board of Directors of Blue Shield be advised that any innovation or other change in or addition to the policy of Blue Shield be discussed with the local doctors involved before it is inaugurated on a trial or pilot plan basis whenever possible. (Motion seconded by Dr. Robert H. Rang, and carried.)

(Doctor Kahler moved the adoption of the report of the Reference Committee on Prepaid Medical Insurance as amended. Motion duly seconded and carried.)

No further business appearing, on motion of Dr. George R. Daniels, duly seconded, the House adjourned, to meet again at 7:30 a.m., Tuesday, October 28, 1952.

## EXECUTIVE COMMITTEE

April 26, 1952

Roll call showed the following present: C. J. Clark, M.D., chairman; W. L. Porteus, M.D.; J. William Wright, M.D.; Paul D. Crimm, M.D.; Wemple Dodds, M.D.

Frank B. Ramsey, M.D., editor of *THE JOURNAL*; Albert Stump, attorney; James A. Waggener, executive secretary; Robert J. Amick, field secretary.

Statements of receipts and expenditures for March for the association and *THE JOURNAL* were approved.

### Membership Report

Number of members, April 23, 1952.....3,438\*

Number of members, April 23, 1951.....3,310

Gain over last year ..... 128

\* Includes 66 in military service (gratis)

97—\$10.00 members (residents and interns)

232—senior members

40—members, dues remitted by Council

### Headquarters Office

The field secretary gave a detailed report of his activities since the first of April, reporting that he had called on 22 counties and reported on some of the situations he found in existence. By consent, the committee requested that the field secretary contact all political candidates in his area, a list of these to be supplied to him by the headquarters office.

The headquarters office was also instructed to prepare a map showing the location of the hospital and the area served for each county and the number of physicians practicing in each county.

1952 Annual Session, Indianapolis,  
October 28, 29 and 30, 1952

Upon motion of Drs. Wright and Crimm, the request of the Indiana Academy of General Practice for an exhibit space was approved.

Correspondence from exhibitors regarding the rule of the committee on limiting exhibits to Council accepted products only was discussed at length. Upon motion of Drs. Portteus and Wright the executive secretary is to survey the other states to determine how many limit exhibitors in this manner and how many disregard Council acceptance as a method of accepting exhibits, and a report is to be made upon the finding at the next meeting of the committee. Doctor Crimm dissented to this action.

#### Organization Matters

Request of Indiana University for use of the mailing list in distributing the research reprint was approved upon motion of Drs. Wright and Dodds.

Request of the School of Practical Nursing for mailing brochure with the News Flashes was approved on motion of Drs. Wright and Portteus.

The letter from the Governor's Committee was discussed and the president was empowered to contact other organizations for suggestions as to who might be recommended to receive the award, and the executive secretary was to inquire as to what other organizations will participate in making nominations, upon motion of Drs. Portteus and Crimm.

By consent, the committee suggested the executive secretary forward the correspondence received from other states in the matter of licensing physicians from foreign schools for service in state mental hospitals to Doctor Nielsen.

Letter from Dr. Earl Leinbach was read and the headquarters office is to compile information on other communities and report back at the next meeting.

By consent, the executive secretary was instructed to attend the meeting being called by the Indiana Manufacturers Association on Thursday, May 8.

#### The Journal

*Report on advertising* was accepted by consent:

Total, April, 1951	-----\$2,181.83
Total, April, 1952	-----2,184.02

Upon motion of Drs. Wright and Portteus, medical students, interns and residents are to be granted the privilege of subscribing to THE JOURNAL of the Indiana State Medical Association at a subscription rate of \$3.00 per year.

There being no further business, the committee adjourned to meet again at 6:00 p.m., Friday, May 16, 1952, at the Athenaeum, Indianapolis.

## COUNCILOR DISTRICT MEETINGS

### FOURTH DISTRICT

Nearly one hundred physicians and their wives attended the forty-eighth annual meeting of the fourth district, held at the Madison Country Club, Madison, on April 30, 1952.

The golfers teed off for their annual tournament at 9:00 a.m. with Robert O. Zink, M.D., Madison, crowned the best golfer of the day.

Following a Smörgåsbord luncheon, the members convened for their business meeting, and election of district officers. Dr. T. D. Carpenter, Columbus was elected President; Dr. J. M. Black, Seymour, Vice-president; and Dr. H. E. Rothring, Columbus, Secretary-treasurer. The 1953 meeting will be held at Columbus.

The scientific program featured two papers; one by Dr. Glenn W. Irwin, of I. U. Medical School, on "Some Practical Aspects of Cortisone and ACTH Therapy." "Some Problems in Pediatric Urology" was the title of a paper given by Dr. Robert Garrett, of the Medical School.

The Auxiliary was entertained with a tour of the President's new home at Hanover College and a tea at the home of Dr. and Mrs. George May.

Guests introduced were: J. William Wright, M.D., Indianapolis, president, Indiana State Medical Association; Charles Overpeck, M.D., Greensburg, Councilor; Jas. A. Waggener, executive secretary, and Robert Amick, field secretary.

### SIXTH DISTRICT

Approximately fifty members attended the annual sixth district meeting held in the Elks Club, Rushville, on April 24, 1952. W. U. Kennedy, M.D., New Castle, was re-elected Councilor. District officers named were: H. P. Ross, M.D., Richmond, President; Robert W. Kuhn, M.D., Wilkinson, Vice-President; John E. Fisher, M.D., New Castle, Secretary-Treasurer.

The Fayette-Franklin Society will be host for the 1953 meeting.

The group was welcomed by Francis Mountain, M.D., District President, and W. U. Kennedy, M.D., councilor, gave an interesting talk on his recent trip to Europe.

The scientific program was composed of a paper on "Diagnosis and Management of Polomyelitis" by John E. Allen, M.D., of Cincinnati. "Headaches" was the subject of a paper given by E. Vernon Hahn, M.D., Indianapolis. The "Diagnosis and Treatment of Peripheral Vascular Diseases," was the title of a paper by Harris B. Shumacker, Jr., M.D., Indianapolis.

Members of the Auxiliary were guests for the meeting.



# Clinical Results\* with Banthine® Bromide

(Brand of Methantheline Bromide)

## 22 Published Reports Covering Treatment of 1443 Peptic Ulcer Patients with Banthine

Comprising the reports published in the literature to date which give specific facts and figures of the results of treatment

AUTHORS	No. of Patients	Chronic, Resistant to Other Therapy	TYPES OF ULCERS				RELIEF OF SYMPTOMS (Chiefly Pain)				Surgery or Complications <sup>1</sup>	Side Effects Requiring Discontinuance of Drug <sup>2</sup>	EVIDENCE OF HEALING			
			Duodenal	Jejunal	Stomal	Gastric	Good	Fair	Poor	No Report			Complete	Moderate	None	No Report
Grimson, Lyons, Reeves	100	100	93	7			80	11	4		5		47		19	29
Friedman	15	15	14			1	5		4	6 <sup>3</sup>			2			13
Beggaard, Nielsen, Bang, Gruelund, Tobassen	26	26	21			5	16	4	6				8	6	12	
McHardy, Browne, Edwards, Marek, Ward	162		162				136	12	11		3	1	14	9	7	129
Segal, Friedman, Watson	34	34	34 <sup>4</sup>				14	13			7	2	5		8	14
Brown, Collins	117	99	117				97	7	8		5	8	55	9	8	40
Asher	77		65		7	5	52	9	16			16		9	21	47
Rodriguez de la Vega, Reyes Diaz	5	4	5				4		1					3	2	
Winkelstein	116	116	102	8		6	102		14				53		18	45
Hall, Hornisher, Weeks	18	18	18				11		1	6 <sup>5</sup>			18			
Maier, Meili	38	38	24			14 <sup>6</sup>	27	7	4 <sup>7</sup>				10	2	5	21
Meyer, Jarman	25	18	25				21		4							25
Poth, Fromm	37	37	37				33	3	1				33	3	1	
Plummer, Burke, Williams	41	41	41				36		5				38		3	
McDonough, O'Neil	104	100	104				63	10	31			11	4		11	89
Bioders	60	60	58		1	1	35	19	6				10	1	49 <sup>8</sup>	
Legerton, Texter, Ruffin	11		11				11									11
Holoubek, Holoubek, Langford	76	69	76				35	27	10		4	10	26		10	36
Ogborn	42		39	2		1	42 <sup>9</sup>									42
Shaiken	48	48	48				33	10	3		2		33	10	3	
Johnston	145	145	145				143		2			2	143		2	
Rossett, Knox, Stephenson	146		141			5	146					4 <sup>10</sup>	53			93
TOTALS	1443	968	1380	17	8	38	1142	132	131	12	26	54	552	52	179	634
PERCENTAGES			95.6	1.2	0.6	2.6	81.3	9.4	9.3			3.7	70.5	6.6	22.9	

1. Not included in tabulations.

2. Included in "Relief of Symptoms" as "Poor" and in "Evidence of Healing" as "None."

3. Four had no symptoms when Banthine therapy was begun.

4. Of which seven were penetrative lesions and five partially obstructive.

5. No symptoms were present in four.

6. Two with symptoms only; no demonstrable ulcer.

7. Three were psychopathic patients and one had a ventricular ulcer of the lesser curvature.

8. Roentgen findings after treatment period of two weeks; forty-seven had duodenal deformity.

9. All returned to work within a week.

10. In these four, after relief of symptoms, Banthine was discontinued because of urinary retention.

During the past two years, more than 200 references to Banthine therapy in peptic ulcer and other parasymphatonic conditions have appeared in medical literature. Of these reports, 22 have presented specific facts and figures on the results of treatment in a total of 1,443 peptic ulcer patients, 67.8 per cent of whom were reported as chronic or resistant to other therapy. These results are tabulated above and show:

"Good" relief of symptoms was obtained in 81.3 per cent of the 1,405 patients on whom reports were available.

"Complete" evidence of healing was obtained in 70.5 per cent of the 883 patients on whom reports were available.

In all but 9.7 per cent, relief of pain was "good" or "fair." In all but 22.9 per cent, evidence of healing was "complete" or "moderate."

During treatment, 26 patients required surgery or developed complications other than ulcer which required discontinuance of the drug before results could be evaluated.

Of the remaining 1,417 patients, only 3.7 per cent experienced side effects sufficiently annoying to require discontinuance of the drug.



\*Volume containing complete references, with abstracts of 39 additional reports, will be furnished on request by

G. D. SEARLE & Co., P. O. Box 5110, Chicago 80, Illinois.

**LOCAL SOCIETY REPORTS**

**Boone County Medical Society** members met at Witham Memorial Hospital in Lebanon on May 6. Fourteen members were present to participate in the telephone seminar.

**Camp Atterbury Medical Society** members met on March 20 at the Army hospital. Following the business meeting, the scientific program consisted of showing of a film on "Normal Kidney Function."

**Cass County Medical Society** members met in Logansport on May 6. Twenty-three members were present to participate in the telephone seminar on Cesarean Section.

**Fountain-Warren County Medical Society** members met in Attica on May 1, when Dr. Frederick A. Loop, of Lafayette, spoke on "Surgery of the Veins." Eight members and guests were present.

**Jasper-Newton County Medical Society** members met at the Brook Hotel, in Brook, on May 7. The guest speaker was Dr. David Bickel, of South Bend, whose subject was "Vaginal Bleeding."

**Johnson County Medical Society** members met at the Johnson County Memorial Hospital in Franklin on April 9. Eleven members were present.

**Lake County Medical Society** members met at Phil Smidt's Restaurant in Whiting on April 17. The guest speaker was Dr. Denton Kerr, of Houston, Texas, who presented certificates to the founders of AAPS. One hundred three members and guests were in attendance.

**LaPorte County Medical Society** members met at Rolling Prairie on April 17. The guest speaker was Dr. Delbert Bergenstal, of New York City, who spoke on ACTH Therapy. Forty-three members were present.

**Lawrence County Medical Society** members met at Bedford on April 9. Eight members were present to hear a wire recording on "Tumors of the Breast."

**Montgomery County Medical Society** members met at the Culver Hospital in Crawfordsville on April 17. A tape recording on "Medical Emergencies" was run. Twenty-six members were present.

**Parke-Vermillion County Medical Society** members met at the Vermillion County Hospital in Clinton on April 16. Dr. J. K. Berman, of Indianapolis, was the guest speaker. His subject was "Newer Aspects in Surgical Treatment of Cirrhosis of the Liver." Twelve members were present.

**Putnam County Medical Society** members met at the Old Trail Inn in Greencastle on April 11. Twelve members were present to hear Dr. A. P. Warman, of Indianapolis, speak on "Child Psychiatry."

**Rush County Medical Society** members met at Rush Memorial Hospital in Rushville on April 10. Dr. William Chambers, of Cincinnati, spoke on "Spinal Cord Tumors."

**Shelby County Medical Society** members met at the W. S. Major Hospital in Shelbyville on April 9. Twelve members were present to participate in the seminar on "Care of Infants—First Year."

**St. Joseph County Medical Society** members met at the Hotel LaSalle in South Bend on March 26. Dr. Bayard T. Horton, of the Mayo Clinic, was the guest speaker. His subject was "Histaminic Cephalalgia."

**Vanderburgh County Medical Society** members met at the Hotel McCurdy in Evansville on May 13, in combination with the Tri-State Postgraduate Assembly. The guest speaker was Dr. Eugene M. Bricker, of St. Louis.

**Wabash County Medical Society** members met at the Sheller Hotel in North Manchester on April 9. Eighteen members were present to hear Dr. Harris B. Shumacker, of Indianapolis, speak on "Recent Developments in Surgery of Heart Diseases."

**Wayne-Union County Medical Society** members met at the Leland Hotel in Richmond on April 16, when Dr. E. C. Hamblen, of Duke University was the guest speaker.

**Whitley County Medical Society** met at Whitley County Memorial Hospital in Columbia City on April 8. Nine members were present to hear Dr. John Langohr, of Columbia City, speak on "Differential Diagnosis of Pain in the Right Lower Quadrant."



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**Publicity**—Mrs. F. M. Gastineau, Indianapolis

The Allen County Medical Auxiliary entertained the women attending the eighth annual session of the House of Delegates of the Woman's Auxiliary to the Indiana State Medical Association in Fort Wayne, April 24 and April 25. Over two hundred members and guests assembled to enjoy the entertainment and hear the excellent speakers, to greet old friends, and make new ones.

The business sessions began with a board meeting Thursday noon. Mrs. Frances M. Fargher, our state president, called the first general session to order at 2:00 p.m. During the afternoon the reports of the state vice-presidents and county presidents were given. Many counties evidenced their interest in nurse recruitment, as almost every president reported various types of meetings with high school girls, to acquaint them with the advantages of choosing nursing as a vocation.

It was our good fortune to have Dr. John W. Cline, president of the American Medical Association, for our speaker at the banquet. No greater honor has ever come to the Indiana Auxiliary. We should all thank our president for securing the "top" for our meeting. Doctor Cline, in a very scholarly address, traced the steps of socialism down through the centuries and applied many things that happened in other countries to present-day practices. He re-emphasized the importance of keeping abreast of the times, and of being prepared to conscientiously advise our friends on the dangers of these socialistic trends.

At 8:45 a.m. Friday morning everyone was up to "Rise and Shine for Medicine in Rhyme" at a breakfast in the ballroom. During the general session which followed, committee chairmen reports were given. The president summarized this year of growth and accomplishments in her report. We all felt that such a sparkling personality as hers had inspired us all to make this year a big success.

Tom Hendricks, secretary of the Council on Medical Service of the American Medical Association, was the speaker at the "Johnny Appleseed Luncheon." Mr. Hendricks talked in his informal, humorous way. He made the point through test tube demonstration that we must always guard against dissension from within in order to preserve our organization.

The officers were elected and then installed by Mrs. Charles Voyles in an impressive ceremony. The officers were as follows:

**President-elect**—Mrs. Burleigh Matthew  
**1st Vice-President**—Mrs. Harry C. Harvey  
**2nd Vice-President**—Mrs. Verne L. Turley  
**3rd Vice-President**—Mrs. William Tindall  
**4th Vice-President**—Mrs. M. B. Welborn  
**Recording Secretary**—Mrs. Charles Richardson  
**Corresponding Secretary**—Mrs. B. M. Merrell  
**Treasurer**—Mrs. J. M. Sullivan

Mrs. Hubert Goodman, in her inaugural address, inspired us with confidence in her ability to help us carry on as ever to bigger and better endeavors. Mrs. Goodman announced her chairmen as follows:

**Organization**—Mrs. Burleigh Matthew, Indianapolis  
**Program**—Mrs. F. P. Williams, Huntingburg  
**Legislation**—Mrs. G. W. Dyer, Terre Haute  
**Today's Health**—Mrs. Herbert Sloan, Jeffersonville  
**Publicity**—Mrs. Frank Gastineau, Indianapolis  
**Radio**—Mrs. Dillon Geiger, Bloomington  
**Editorial**—Mrs. Richard Stout, Elkhart  
**Finance**—Mrs. Roy V. Myers, Indianapolis  
**Public Relations**—Mrs. Norman Forsee, Jeffersonville  
**Rural & School Health**—Mrs. Jack Eisaman, Bluffton  
**Bulletin**—Mrs. Milton Gevirtz, Hammond  
**Civil Defense**—Mrs. Lester Bibler, Indianapolis  
**Parliamentarian**—Mrs. Charles F. Voyles, Indianapolis  
**Historian**—Mrs. Philip Rothrock, Lafayette

The delegates and guests wish to thank Mrs. Harry C. Harvey, president of the Allen County Medical Auxiliary and her chairman, Mrs. R. W. Wilkins, and all the committee members for our fine entertainment. We women can all appreciate the hours of planning that made the meeting such a huge success.

## INDIANA STATE BOARD OF HEALTH

### Division of Communicable Disease Control

#### Monthly Report—March 1952

Disease	Mar. 1952	Feb. 1952	Jan. 1952	Mar. 1951	Mar. 1950
Actinomycosis	1	0	0	0	0
Chickenpox	420	605	489	357	283
Conjunctivitis	7	2	0	0	12
Diarrhea	2	12	12	0	0
Diphtheria	8	3	3	12	16
Encephalitis	6	2	3	3	1
Influenza	2681	1105	67	74	113
Infectious hepatitis	40	49	24	38	0
Measles	1876	951	849	1235	1112
Meningitis,					
Unclassified	14	9	3	8	6
Influenzal	1	1	1	0	1
Meningococcal	5	4	2	3	3
Pneumococcal	2	0	0	1	0
Streptococcal	1	0	0	0	0
Mumps	731	660	537	339	195
Pneumonia	73	41	96	64	71
Polio myelitis	1	6	3	4	4
Rabies in animals	26	12	12	37	36
Rheumatic fever	3	0	1	1	1
Rubella	109	67	31	71	79
Streptococcal infections including scarlet fever	299	409	190	313	326
Typhoid fever	1	3	2	4	3
Vincent's angina	2	4	4	0	1
Whooping cough	21	34	86	43	151



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## Books

Books received are acknowledged in this column, and such acknowledgment must be regarded as a sufficient return for the courtesy of the sender. Selections will be made for more extensive review in the interests of our readers and as space permits. Books listed in this department are not available for lending. Any information concerning them will be supplied on request.

**HISTOPATHOLOGICAL TECHNIC.** Second Edition. By Aram A. Krajian, Sc.D., formerly in Department of Pathology, Los Angeles County General Hospital; and R. B. H. Gradwohl, M.D., Pathologist to Christian Hospital; Director Gradwohl School of Laboratory and X-ray Technique, Saint Louis, Mo. 362 pages with 131 illustrations and 7 color plates. Price \$6.75. The C. V. Mosby Company, 3207 Washington Boulevard, Saint Louis 3, Mo. 1952.

**THE CLINICAL USE OF FLUID AND ELECTROLYTE.** By John H. Bland, M.D., Assistant Professor of Medicine, University of Vermont College of Medicine. 259 pages, 75 illustrations. Price \$6.50. The W. B. Saunders Company, West Washington Square, Philadelphia 5, Pa. 1952.

**SPATIAL VECTORCARDIOGRAPHY.** By Arthur Grishman, M.D., Adjunct Physician for Cardiology, The Mount Sinai Hospital, New York; also connected with Beth Israel Hospital, New York; and Leonard Scherlis, M.D., Research Assistant in Cardiology, Mount Sinai Hospital. 217 pages with illustrations. Price \$6.00. The W. B. Saunders Company, West Washington Square, Philadelphia 5, Pa. 1952.

### BOOK REVIEWS

**THE BATTLE FOR MENTAL HEALTH.** By James Clark Moloney, M.D., 105 pages; price \$3.50. The Philosophical Library, Inc., 15 East 40th Street, New York 16, N. Y., 1952.

This book is just exactly what the busy physician needs to bring him up to date on a subject which has attracted nation-wide argument concerning the importance of the first few months of a child's life in the establishment of life-long "mental health." The book is written by a well-known psychoanalyst, who, among a number of others, established in Detroit in 1942 an organization called "The Cornelian Corner." It is unlikely that most physicians outside the field of psychiatry and child health would have the time or the technical know-how to cull the information in this book from the vast and sometimes bitterly argumentative literature in this field; thus, it is very convenient for those who wish to bring themselves up to date to be able to do so by reading this very approachable little book. For those who wish to go further into the literature, a large and very helpfully arranged bibliography is attached, with careful references keyed into the text, and extensive notes where amplification appears desirable.

For any physician or layman interested in child upbringing, mental health—especially in childhood—and related subjects, this book can hardly be recommended too highly.

L.G.M.

**INTRODUCTION TO MEDICAL SCIENCE.** By Julius Jensen Ph.D. (In Medicine) University of Minnesota, M.R.C.S. (England), L.R.C.P. (London) and Henry W. Noller, M.D. Associate, St. Luke's Hospital School of Nursing, St. Louis. Cloth \$5.75. Pp. 533 with 71 fig. C. V. Mosby Company, 3207 Washington Blvd., St. Louis 3, 1952.

This book is designed to orient the student beginning the study of medical sciences. It is quite elementary. As such it will be very useful, especially for those in nurses training or those engaged in studies associated with medicine. It hardly qualifies as a textbook in medicine, yet it contains many medical facts concerning the knowledge of which the student will find helpful.

T.M.C.

**LOW-SODIUM DIET: A Manual for the Patient.** By Thurman B. Rice, M.D., Professor of Public Health, Indiana University School of Medicine, Indianapolis. 103 pages, 14 Food Charts. Price \$2.75. Lea & Febiger, Philadelphia, Pa.

This very timely and useful manual written by our own well-known Thurman B. Rice, M.D., professor of Public Health, Indiana University School of Medicine, and Editor of the Monthly Bulletin of the Indiana State Board of Health, is directed primarily toward the layman, but it is hard to imagine how a physician in these times can avoid having this book on his shelf. It is a guide, in simple non-technical language for those requiring a low-sodium diet, and for their wives or cooks who are faced with the extremely difficult task of maintaining a diet low in salt content. With his wide knowledge of the presentation of technical facts, and the careful avoidance of giving the layman the idea that he can treat himself without the advice of a physician, Doctor Rice has done a wonderful job in a field that will have wide application in general medicine. Very few physicians fail to see patients in congestive heart failure, and within recent years it has been well shown that herein particular adjustment of dietary sodium intake is of paramount importance.

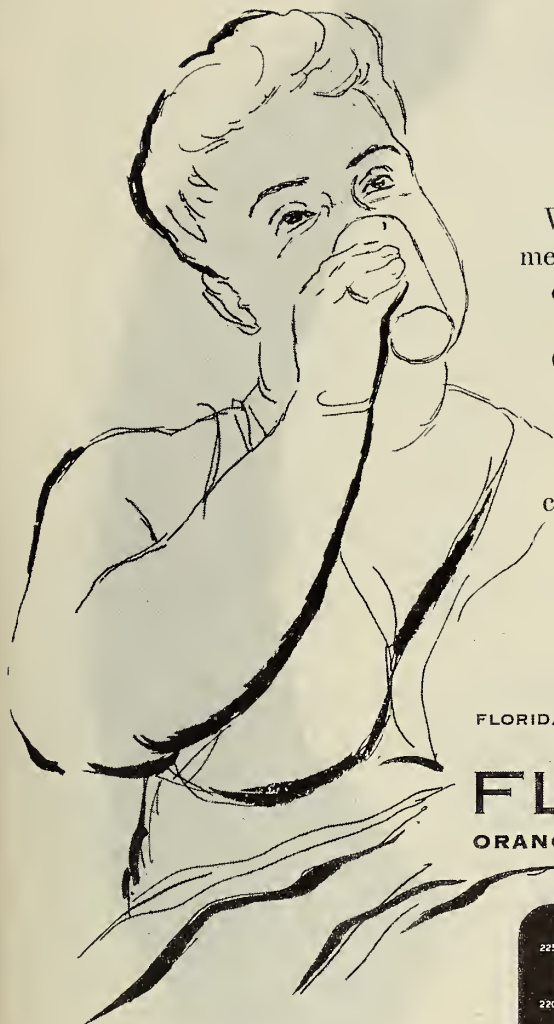
The careful explanation of the low-sodium diet, and its application as might be understood by a layman, is preliminary to chapters including lists of foods according to their sodium content, outlines of diets with various estimated sodium contents, and a large number of recipes which Doctor Rice and Mrs. Rice, his right-hand associate in the study of the cookery of low-sodium foods, have found useful. No one who has attempted to eat a low sodium diet prepared by someone who has not made a study of the requirements, can appreciate how much help these recipes and lists of food can be to the cook who is faced by the necessity of maintaining this kind of diet over a long period of time.

Although almost any physician would find this book of great help in his office, the place that he will probably find it most useful will be in the hands of his cardiac patients who can use this manual in the home.

L.G.M.



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*\* Postgrad. Med. 9:106, 1951.*

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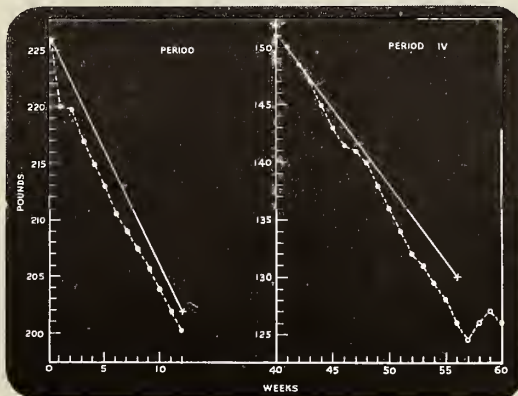


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**RESEARCHES IN BINOCULAR VISION:** By Kenneth N. Ogle, Ph.D., Section on Biophysics and Biophysical Research; Research Consultant in the Section on Ophthalmology, Mayo Foundation and Mayo Clinic, Rochester, Minnesota. 345 pages with 182 figures and 26 tables. Philadelphia and London: W. B. Saunders Company, 1950. Price \$7.50.

This book is a very exhaustive treatise on physiologic optics, especially as it concerns binocular vision. Most of the text consists of data and deductions based on research in these fields as obtained largely in the experimental laboratory, and very little from clinical sources.

The research described deals especially with the organization of the retina and visual pathways, and discusses the sensory cooperation of the retina of the two eyes, and how the visual impressions from each become fused to form a single mental picture which has special localization and stereopsis.

The book is primarily of interest to those who might need an authoritative text on the facts and theories concerning binocular vision, and would be of little practical value to anyone in the general practice of ophthalmology.

J. W. M.

**A TEXTBOOK OF CLINICAL NEUROLOGY—With An Introduction to the History of Neurology:** By Israel S. Wechsler, M.D., Clinical Professor of Neurology, Columbia University, New York; Consulting Neurologist, The Mt. Sinai Hospital, Montefiore Hospital and Rockland State Hospital, New York. New 7th Edition. Cloth \$9.50. 801 pages with 179 figures. W. B. Saunders Company, 218 W. Washington Sq., Philadelphia 5; 1952.

This is the seventh edition of this well-known textbook in neurology. Those who have used this book as a manual in medical school or as a reference in the practice of medicine know its clear method of presentation of a subject matter which by nature is difficult for the average practitioner to grasp.

The first 100 pages deal with the important subject of the correct method of doing adequate neurological and psychological examinations. Parts II, III, IV, comprising 556 pages, describe specific diseases or syndromes of the spinal cord, peripheral nerves and the brain. Each condition is defined, the signs noted, the course, differential diagnosis, and treatment outlined. Appropriate references follow the discussion of each disease. Remarkable is the completeness yet brevity of each topic presentation.

Part V deals with the neuroses. A short historical introduction precedes a discussion of mental mechanisms, the etiology, clinical manifestations, diagnosis, course, prognosis, and treatment of this important group of illnesses. Here, too, Dr. Wechsler stays on solid ground. In 48 pages he presents most of the concepts accepted as being fundamental to the present day understanding of the neuroses. The reader feels safe in the knowledge found here—not confused or bewildered, as so often happens in presentations less well organized.

Students interested in historical background of medical subjects will delight in the last part of this book in which the history of neurology is discussed in some detail and with many references.

Although thoroughly revised, brought up to date, and improved to accord with present state of knowledge, this book still has preserved its original pattern of presentation, of being comprehensive, clearly outlined, brief yet complete—features which have always made it a good textbook and a reliable reference.

T.M.C.

## THE SPECIALITIES IN GENERAL PRACTICE.

Edited by Russell L. Cecil, M.D., Professor of Clinical Medicine, Emeritus, Cornell University Medical College, New York City, 818 pages with 470 figures. Price \$14.50. W. B. Saunders Company, Philadelphia 5, Pa., 1951.

This book consists of fourteen sections, each written by a distinguished authority in a specialized branch of medicine, with the intent of helping the physician in general practice to orient himself to the special problems commonly met in daily practice. Its chief merit lies in the fact that although written by authorities in the specialties, it is designed for the family physician.

The aim is to help him in the correct diagnosis of conditions which he encounters. The general practitioner is encouraged to give reasonable and proper therapy in the cases that fall within his capability of managing. Procedures of handling specialized problems are outlined with appropriate warning against making certain common mistakes. Through re-education the family physician is urged to recognize his limitations.

Special interests of respective authors are noticed in each chapter. Such pet subjects, presented perhaps in detail out of proportion to related topics, seems excusable when it is realized that the information is offered by a specialist deeply interested in the subject and therefore probably has much value.

This book is truly a one-volume refresher course in fourteen branches of medicine.

T.M.C.

## PHYSICAL MEDICINE AND REHABILITATION FOR THE CLINICIAN.

Edited by Frank H. Krusen, M.D., Professor of Physical Medicine, Mayo Foundation and Consultant in Pediatrics, Mayo Clinic, Rochester, Minn. 371 pages and numerous illustrations. Price \$6.50. W. B. Saunders Company, Philadelphia 5, Pa., 1951.

This text is a compilation of articles by a number of authorities in the field of physical medicine and rehabilitation, most of whom are members of the staff of the Mayo Clinic, and the University of Minnesota, with additional articles contributed by outstanding authorities from other parts of the country. The whole compilation is edited by Dr. Frank H. Krusen, Professor of Physical Medicine and Rehabilitation of the University of Minnesota and Head of the Department of Physical Medicine of The Mayo Clinic, Rochester, Minnesota.

It is extremely difficult for the physician, unless he is actively engaged in physical medicine, to keep in touch with the rapid strides in this most recent field of medical specialty. This book is an ideal method of bringing the physician up to date in an interesting and instructive way.

The various lectures comprising this volume are arranged in four major sections dealing with (1) Therapeutic Applications of Physical Agents and Procedures, (2) Diagnostic Applications of Physical Agents and Procedures, (3) Clinical Aspects of Physical Medicine and Rehabilitation, and, (4) Fundamentals of Anatomy, Therapeutic Exercise and Physiology as related to Physical Medicine and Rehabilitation.

No industrial physician or physician dealing in orthopedics or other aspects of physical medicine or rehabilitation can afford to be without this excellent volume, and it is an ideal text for the general practitioner to use as a refresher in this field.

L.G.M.



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**TEXTBOOK OF REFRACTION:** By Edwin Forbes Tait, M.D., Ph.D., Associate Professor of Ophthalmology, Temple University School of Medicine; Attending Surgeon (Ophthalmology), Temple University and Montgomery Hospitals, 418 pages with 93 figures. Philadelphia & London: W. B. Saunders Company, 1951. Price \$8.00.

This is a handsome, well illustrated, and well arranged book which, according to the author, is particularly directed toward the field of teaching for both undergraduate and graduate students of ocular refraction and neuromuscular abnormalities. It has been designed to meet a need for a practical textbook, and is an amplification of the classroom, laboratory, and clinical outlines and notes used by the author in his teaching. It is pointed out that many obsolete and erroneous traditional concepts have been deleted from this text, and only those areas of knowledge of the field which are believed by the author to be of real value to the student are included. This has made it necessary to leave out some of the work of pioneers in the field of ocular refraction and related subjects, and the author has presented his beliefs concerning "an acceptable philosophical approach and effective methodology based on modern knowledge of the subject and of the sciences basic to it."

The useful element in this book is the inclusion of pertinent references at the end of each chapter rather than in a long list at the end of the book. The author points out that references have been carefully selected with an eye to the fact that the book is primarily for students preparing for practice in the field of ophthalmology; for this reason the references are largely to sources of information of a practical nature, and many that might be of interest to the theorist or research worker have been omitted because of their controversial nature.

The author defends a somewhat unusual order of organization of material contained in the text on the grounds that his years of experience have suggested such an order of subject matters. Some material does not appear in this book, or appears only incidentally, because the author presupposes that the reader has a general knowledge of the physiology and anatomy of the eyes and nervous system, and an understanding of the principles and method of geometric and physiologic optics.

There is no doubt that this is a fine student's text, and will make an excellent basis for review or reference for the practicing ophthalmologist.

L. G. M.

**CALLANDER'S SURGICAL ANATOMY (Third Edition).** By Barry J. Anson, M.A., Ph.D., (Med. Sc.) Professor of Anatomy; and Walter G. Maddock, M.D., Elcock Professor of Surgery, both at Northwestern University Medical School. 1074 pages with 929 illustrations. Price \$14.00. W. B. Saunders Company, Philadelphia 5, Pa., 1952.

This classic and always popular textbook of surgical anatomy has been carefully and advantageously revised for the new 3rd Edition and is one of those reference "musts" for the library of the general practitioner, intern, resident, the general and specialized surgeon. Both the text and illustrations have been modernized, and more than 300 new illustrations have been added. All the illustrations are excellently detailed and every surgical step carefully and simply explained with an accompanied index. Of special interest and help to the busy surgeon is the material on anatomical variations and anomalies—here the reproductions of the normal with the numerous variations encountered at the operating table are excellently portrayed. Each system of the body is individually dealt with, landmarks are illustrated, and the best surgical approaches indicated. There is important new information on chest and cardiac surgery; surgical approach to the knee; inguinal hernia; and many other topics.

The general plan of presentation remains as in previous editions; basic anatomical structure is discussed as an introduction to the described and illustrated operative technique. The format and type are excellent, which makes for easy reading and reference.

All in all, this is applied anatomy at its best, supported by an excellent and well integrated text, and edited by a highly competent team of trained anatomist and practicing surgeon.

This atlas has proved its usefulness in the past, is reasonably priced, and is recommended to everyone interested in surgery as a valuable reference volume.

R. H. M.



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## *Opinions From Here and There*

**Prepared for your information by the Committee on Public Policy and  
Legislation of the Indiana State Medical Association**

This marks the first major attempt of the Committee on Public Policy and Legislation to better inform the members of the Indiana State Medical Association on political affairs and legislative matters. Permission has been granted to test this new service to the members of ISMA for the next few months. Your comments on and suggestions as to the value of this insert in your JOURNAL each month will be greatly appreciated by the Committee and will determine the value of spending the time and money in compiling the information contained herein.

\* \* \* \* \*

The plan is to give you each month bits of information on legislation which we hope will help you become better informed on "what's goin' on" in the field of legislation and politics.

\* \* \* \* \*

### **NATIONAL**

June 17—While it may be old news by now—a slick piece of political maneuvering enabled administration forces to steam-roller through the House of Representatives the controversial HR 7800. Tacking the provision on the bill, in committee, to permit FSA administrator Ewing to regulate physical examinations and prescribe physicians and their fees for the service, for social security recipients, along with provisions for increasing the SS benefits, forced congressmen to vote the measure through rather than take more criticism from the people receiving social security. The bill came to the floor of the House under gag rules which limited debate to 40 minutes and did not permit amendment. The bill was defeated on May 19. Coming back for a vote again on June 17, it passed 360 to 22. Many congressmen are of the opinion the present bill does not contain the objectionable section 3. However, the AMA is of the opinion the bill as passed is worse than the original bill. While the wording has been changed, it now provides for the FSA administrator to administer the bill "as he deems necessary," which is interpreted as providing a blank check for him to again write his own regulations.

If he follows out the intent behind the bill, this marks the first major step by the federal government in bringing about socialized medicine, as it provides controls on fees and services in connection with the physical disability section of the act.

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Through the efforts of the AMA section three was removed from the bill by the Senate Finance Committee. They also removed section six (deal-

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ing with wage earners covered by state and local retirement systems) and increased beneficiaries' income ceiling to \$100. It is predicted an attempt will be made to restore this section by amendment from the floor of the Senate.

\* \* \* \* \*

Plans are being laid for a campaign to defeat the bill in the Senate, and societies will be alerted as to how they can help. When this time comes it is hoped complete cooperation will be lent to the effort.

\* \* \* \* \*

In the meantime it is hoped every physician will familiarize himself with the bill and be prepared to discuss it with his patients and friends.

\* \* \* \* \*

Lack of debate on the bill did not enable the public to understand the issue. Most social security recipients have the idea that the medical profession has been working against their receiving increased benefits of approximately \$5.00 per month. This is not true; the medical profession has not opposed the cost of living increase in benefits—only section 3, which starts a program of socialized medicine through the FSA.

\* \* \* \* \*

This measure is going to be a difficult one to defeat, because of the great pressure being exerted upon Congress by social security recipients.

\* \* \* \* \*

Medicine's stand in this issue must be made clear to these people if we are to have any chance of removing section 3. The public probably doesn't want socialized medicine this way—but they do want more money.

\* \* \* \* \*

**Socialism a Threat Through United Nations.** Some time ago the association informed you of the danger of the International Labor Organization, an adjunct of United Nations, adopting a treaty this year at their annual meeting in Geneva, which will bring about socialization of the world's insurance industry.

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In a report made by President Bauer before the recent meeting of the AMA House of Delegates in Chicago, it was pointed out that another matter of major importance on the agenda of this group is the discussion of minimum standards for Social Security, including medical care. If adopted by the conference, it will then be sent to all member nations of the ILO (of which the United States is one) for ratification. Ratification of these treaties by the United States would seriously affect the status of medical care for patients, as well as the status of the medical profession in this country, as well as the total insurance industry.

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Details of the proposed plan can be found in a large volume, Report V (a) (2), Minimum Standards of Social Security, issued by the International Labor Office in 1952.

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It is interesting that not one practicing physician was on the consultant group of medical experts who reviewed the medical provisions of the proposed convention.

\* \* \* \* \*

The World Health Organization, in which the AMA is most active, has lodged a vigorous protest with ILO.

\* \* \* \* \*

To further add weight to the WHO protest the House of Delegates of the AMA adopted the following resolution directed to Congress:

*Resolved*, That the American Medical Association strongly favors an amendment to the Constitution of the United States which will provide that no treaty or executive agreement shall be made which conflicts with any provision of the Constitution of the United States or which operates or may operate to regulate any of the purely domestic affairs of the United States; *Be It Further*

*Resolved*, That the American Medical Association therefore endorses in general the principles set forth in Senate Joint Resolution 130; and *Be It Further*

*Resolved*, That copies of this resolution be sent to the chairman of the Senate Judiciary Committee, the President of the Senate, and to the Majority and Minority leaders of the Senate.

\* \* \* \* \*

**Would Limit Federal Taxing Power.** In another resolution adopted by the AMA House of Delegates the AMA calls for a limit to the federal taxing authority. The resolution is as follows:

*Whereas*, Federal taxation has shown a steady tendency toward unlimited increase; and

*Whereas*, Such heavy federal taxation limits the state and local units of government in their taxing ability; and

*Whereas*, The trend of taxation by the federal government is rapidly destroying the economy of this nation; and

*Whereas*, If this trend continues, the state and local governmental units will become impotent and will in time have to rely entirely on doles from an all powerful federal government; and

*Whereas*, It is felt that each physician should accept his responsibility not only as a physician but as a citizen, and should actively participate in all matters at local, state and national levels that will help preserve those principles of government upon which this nation was founded:  
*Therefore Be It*

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*Resolved*, that the House of Delegates of the American Medical Association go on record as favoring an amendment to the Constitution of the United States limiting the taxing power of the federal government.

\* \* \* \* \*

**President's Committee on the Health Needs of the Nation.** Headed by Dr. Magnuson, this committee was labeled purely political by the AMA. In a hotly debated issue during which Dr. Magnuson made a personal appearance before the reference committee criticising the AMA attacks upon his commission, the House, after tabling the resolution condemning the commission, again considered the matter by adopting a resolution upholding the Board of Trustees and the AMA in their stand.

\* \* \* \* \*

## LOCAL

Your Association has been requested to submit suggested platform planks for both Republican and Democrat parties. Your committee has submitted suggested planks asking for maintenance of medical education standards and for opposition to Compulsory Health Insurance Legislation.

\* \* \* \* \*

Now is the time to get acquainted with your candidates for the State Legislature. The chiropractic issue will be up again. Chiro's are now attempting to place candidates on record as favoring a chiropractic board.

\* \* \* \* \*

It is good policy to keep in close contact with all your congressmen, let them know how you feel, and drop them a note of appreciation when they do something you like. Requests for help mean much more when they have also received some roses for their past help.

\* \* \* \* \*

**450 Physicians Face Draft.** A call for this number of priority one physicians has been made for the month of August. The Army is to get 100 of these, while the Air Force will take 350.

\* \* \* \* \*

**SB 1140 Rejected by Senate Committee.** This bill to create a Department of Health has been turned down and a substitute bill (SB 3314) to set up a Federal Board of Hospitalization has been introduced. A study is being made on this substitute measure. At this writing the bill appears to be the same as old bill 995 which was not objectionable; however, the main provisions of 1140 have been added in an attempt to slip them through. More on this later.

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# THE JOURNAL

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## THE AMERICAN MEDICAL ASSOCIATION\*

### A Public Service Organization

EDWARD J. McCORMICK, M.D.†

*Toledo, Ohio*

HERE is little doubt in my mind that many doctors and most people in the United States of America look upon the American Medical Association as an organization devoted to the interests of the doctors. In many instances the Association has been referred to as a union or a trust. There are many doctors and laymen who are unaware of the many services offered by the American Medical Association to the public of our country. It is these services that I wish to discuss and the activities of the American Medical Association, and I feel that such a discussion at this time in the history of the United States of America is important.

A constant reaffirmation of the fundamental and eternal values is needed more in America today than ever before in our history. Too many of our people, made soft by the cornucopia of democracy and unappreciative of the blessings which are coming to them, are inclined to listen

to the propaganda which is heard over the radio and printed in newspapers and magazines and presented as the brain child of so-called economists who infest our centers of learning and who have, during recent years, gained the spotlight in the United States by their activities in government affairs. There is nothing so discouraging to one interested in the permanency of a government which has been established to protect individual rights than to hear constantly through many channels that the government should become larger, more bureaucratic, more centralized, should have more money and should support and pay more people.

We Americans, a rich people actually stupefied by opulence in all ranks of our national life, find ourselves being led down the socialistic way of Marx to eventual collectivism and communism and we offer feeble resistance. We seem willing to turn over to government employees all of our responsibilities. As most of our people sit idly by enjoying the wealth of this country, certain political forces insist that we must "go

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\* Presented at the Conference of County Medical Society Officers, at Indianapolis, March 2, 1952.

† President-Elect, A.M.A.

broke" in order to continue in riches and that government spending and pump priming is the only way to success. So we approach the bar of bankruptcy on the skis of inflation and soon history will record, "the Americans were a great people."

And who among us has not listened with interest to the economist and the social worker, who in many instances have one aim and purpose in life, namely, to spread the gospel of individual dependency. It is the theory that the individual has a right to become more and more dependent upon government and that government has the right to collect more and more taxes to support people that is leading us into a pathological social state which will destroy America. We hear these theories and doctrines frequently supported by elected officials, ranking labor leaders, some industrialists and capitalists, and members of the clergy and the professions, who in many instances are uninformed and overcome by humanitarian instincts. It is indeed easy to support these theories and doctrines if we desire to pass a constantly increasing debt to the taxpayers of this and future generations, and give more and more power to those who would like to establish themselves permanently in the nation's capitol as dictators of a dependent people.

There is too little appreciation of the fact that democracy as we know it in America today has made us, the sons and daughters of immigrants, the richest people in the history of the world in less than 200 years. When you stop to consider that Americans own the greater percentage of everything worth owning in the world, one wonders why so many people should be out to disturb and destroy such a desirable situation. Here we have the greater percentage of the world's radios, television sets, automobiles, good clothes, food, gold, stocks and bonds, recreations of all kinds, homes and freedom of speech, of religion, of the press and freedom of assembly. There are few in our country who do not have some or all of these luxuries. Certainly the poorest in America have more of these desirable possessions than do many of the so-called wealthy people in other countries. It has not been written or decreed that everyone should possess all luxuries but it is our belief here in America that all should have opportunity to gain as much of the world's goods

as they can properly earn through their own efforts. God created us equal as far as opportunity is concerned but he did not intend to create men equal mentally and physically and there shall never be a time or a place when we shall be equal in worldly possessions, although we Americans have come closer to this than any other people in the world's history. We have come to the point in our economy where, as a matter of fact, we are the only country in existence with anything substantial to offer. That we are thoughtful of those who are less fortunate is certainly proven by the fact that at the present moment we are probably supporting a great portion of the world as well as extending generous help and aid to our own less fortunate. Almost every country in the world today is the beneficiary of American democracy and in some instances we are giving money and goods to countries which are embracing ways of life which are not only undemocratic but irreligious. We are giving money and goods to countries that openly teach that people were created for the government and not government for the people.

The prescription of American success has been that of private enterprise and ownership. The economists who have conceived the senseless theories which hold only empty promise are not ignorant men and we must therefore conclude that in some instances they are deliberately deceptive. We know that many of them cannot believe in democracy and the right of the individual because they do not believe in God and therefore they work day and night in the classroom, over the radio and through all channels to destroy the belief of Americans in their own way of life and lead them eventually into the poverty and slavery of Stalinism, collectivism, socialism or communism. It will be a sorry day when American students and their older fellow citizens come to believe that they are entitled to everything without effort on their own part or that this government owes them a living or that dependency is an achievement.

There is nothing new in the foolhardy economic conceptions which we read in our press and in our magazines each day. Hammurabi established a code two thousand years before Christ and imposed controls over wages, prices, production and consumption, and his country, Babylonia, was wrecked. Anyone with an eye



to see and an ear to hear can learn that such bureaucratic activities, coming during prosperity, wrecked Greece, the Roman empire and Spain. It has been recorded that the Incas were debilitated and conquered as a result of the welfare state which they created. These are historical facts. In our present day we have only to look at England, at France, at Germany, and at any other country in the world which has attempted the same program and we will see countries which have been destroyed as world powers and whose people are poor and undernourished because they have been convinced by politicians that it pays to trade freedom for promised security. There can be no true security which is not established by the individual himself and the individual who is overburdened by a bureaucratic state will have no opportunity to provide for his own security. If socialism, collectivism, and communism had been successful in any place in the world during the long history of the world, there would be some reason for us here in America to consider changing the fundamental laws laid down by our founders. It would seem to me that we should be intelligent enough to recognize the fact that when Winston Churchill comes to the United States on a begging mission, as he has done on one or more occasions, that his country, proud England, has been reduced by socialism and communism and constant talk of individual security to a point where England is no longer self-supporting. It is time that Americans started to look with jaundiced eyes upon some professional do-gooders, trained social workers, some educators, many politicians and others who are constantly advising greater security, more for this group at the expense of some other group, more controls, fewer states rights, more government dictation, more bureaucrats, more centralization. What they are actually preaching, of course, is a doctrine which will destroy America as it has destroyed Babylonia, Greece, Rome, England, Germany, and every other country or state which has gone down the welfare road advocating individual mediocrity and leading its people into a heaven of serfdom where someone who looks very much like Stalin is God. There can be no doubt at the present moment regarding the ultimate aims and purposes of this group. They are not striving for security, they are not protecting individual liberty, they are tearing

from the hearts of American students the belief in God, undermining democracy, and if they are permitted to continue without interruption, there is little doubt that they will eventually take down the American flag.

One of the organizations which has constantly opposed socialism and dependency in this country is the American Medical Association. We can say without fear of contradiction that there is no other large organization which has made the unselfish contributions to the preservation of democracy that have been made by the doctors of this country. The American Medical Association is composed of 135,000 professional men and women and it is a society organized for the express purpose of making contributions to the health and welfare of the American people. It is an organization which has found it necessary during recent months and years to use all of its resources to protect American citizens from the inroads which are being made by the un-Americans in the fields of individual liberty and states rights. The Association has as its objective "the promotion of the science and art of medicine and the betterment of public health." It is an organization which has been created to serve the physician and the general public. The American Medical Association each year approves a very large budget. Millions of dollars which are spent come largely from our members and from our scientific publications. I can say without fear of contradiction that a large percentage of the money expended by the American Medical Association is for public service. We have created a Council on Medical Education and Hospitals, a Council on Medical Service, a Council on Food and Nutrition, a Council on Industrial Health, a Council on National Emergency Medical Service, a Council on Pharmacy and Chemistry, a Council on Physical Medicine and Rehabilitation, a Council on Rural Health, a Bureau of Health Education, a Bureau of Investigation, a Committee on Cosmetics, a Committee on Pesticides, a Bureau of Medical Economic Research, a Committee on Nervous and Mental Disease, and a Committee on Research, and we support laboratories for chemical and microbiological and physical investigations. The Commission on Chronic Illness is supported largely by the American Medical Association, as are many other humanitarian projects. The Association has given a million dollars in the past

two years to the nation's medical schools and individual members are giving each year large sums to aid the cause of medical education. The Association financed Blue Shield in its formative period. During 1951, \$619,973.37 were given to such endeavors as the World Medical Association, the National Research Bureau, the Committee on Careers in Nursing, the National Health Council, the National Fire Prevention Association, the National Committee on Traffic Safety, the Conference on Communism, the Commission on Chronic Illness, the Survey on Medical Education and the American Medical Education Foundation. The sums given to these endeavors plus the money expended for the work of the numerous councils, bureaus and other departments maintained for the public good totaled \$2,243,880.42. During the past few years it has been necessary for the American Medical Association through voluntary contributions, and later through dues, to collect and expend hundreds of thousands of dollars to oppose creeping socialism in this country. We have carried the burden in an effort to bring to the American people the fact that Democracy would surely perish with the advent of socialized medicine or compulsory health insurance. We have slaved for hours and spent this money because we know that good medicine cannot come to the people under bureaucratic control and because we are Americans who know that government medicine is the first step to all-out socialism and dictatorship. Doctors have fought and died in all wars and we are willing to give our all on the political front that freedom may not perish from the face of the earth.

We are, it is true, a scientific organization endeavoring to make better doctors and to have better medical schools. This is, in the final analysis, a protection of the public as are all the activities of the American Medical Association. Our Washington office was created not to protect doctors but to protect the public from health legislation which might be enacted and not serve the general good. We are, therefore, a public service organization. Despite what may be said, our efforts and our work have been unselfish. Our legislative activities have been for the protection of the people and not for the protection of the doctor. We can justly state that we are serving America and its peoples and that even our scientific activities are for the improvement

of doctors, that the people may be better cared for.

It is unfortunate that much of our effort must be devoted to a fight against socialism. In this battle we are not especially concerned with the doctor's individual welfare but we are concerned with the preservation of American tradition and the American way of life. I am proud that we have led the battle to preserve American democracy.

The officers and trustees and those who are members of the various councils of the American Medical Association are making a tremendous sacrifice. The Board of Trustees must spend much time each year trying to solve the problems which are facing American medicine and directly and indirectly facing the American people as far as their future welfare is concerned. This is indeed a contribution and it is high time that all of us came to realize that there is little honor in such an arduous job and that the least any of us can do is to support loyally those who are our leaders and who are directing the Association in its efforts to protect the health of the American people and to protect democracy. Unless we can have other organizations and professions doing the same type of work, the outlook as far as American democracy is concerned is indeed very poor. The time has come when every educated man with the ability to think must rally to the cause or all that we have won will be lost, and I think we can say to our friends in the profession of law, to our friends in the clergy, to our friends in the engineering profession, to our friends in the teaching profession and to our friends in all walks of life "Go thou and do likewise" that America may be preserved, that its peoples may continue to enjoy luxury and that they may provide, through their individual efforts, for their own security. It is time indeed that centralized bureaucratic dictatorial government be curtailed in America, that bogus and decadent old-world philosophies be forever done away with, that Americans once more be taught pride in achievement, and that dishonesty and political subterfuge be banished from all media of communication. We must teach our children and our adults a respect for our valiant forebears and an appreciation for the things which we have gained which have never been attained by any other people in history. We as members of the American Medical Association



must let it be known in no uncertain way that our objection to the socialization of the medical profession rests on the basis that we know from bitter experience in other countries that the health of the people cannot be served by such a program, but above all, when such a program is introduced as a beginning of the socialistic or communistic state, that not only the health of the people is endangered but their liberties, their right to worship as they see fit and their right to think and to speak and write as they see fit, are likely to be lost. We in the American Medical Association, a public service organization, have been and are spearheading a fight against the invasion of the rights and liberties of the people of this country, and we are fighting a battle which is probably more important than any battle that has been fought in an actual war within the lifetime of any of the present generation. America shall be preserved eventually not by bullets and not by the sword but by people who have the fortitude to tell the truth as it has been told by the officers and members of the American Medical Association and of our state medical associations and county societies. Every citizen must leave his office and sacrifice some of his recreation time and give of his money to aid in the teaching of American fundamentals, or George Washington, Abraham Lincoln, Benjamin Franklin and Thomas Jefferson will have lived and fought in vain.

### Discussion

Lall G. Montgomery, M.D., (Muncie):

This is an outline of a plan by which a physician can help to fight the threat of socialism, and cultivate among his patients an understanding of the principles and advantages of Americanism.

The plan is outlined in such a way that any part, or any combination of parts, may be used.

For those who have time and inclination this plan may be elaborated upon and extended indefinitely.

The important point is that every physician use at least *SOME* part of the plan *at once*, and continue to use it, so that our patients may be warned in time to check the disastrous trend toward socialism and the welfare state.

### THE PLAN

This plan will take very little time and will cost very little.

It is outlined in sections to make it quickly understandable.

One or more of the sections may be used without the others.

Any part, or all, may be expanded or elaborated.

#### 1. THE WAITING ROOM

Make the waiting room a "School for Americanism."

Make the patient's waiting time learning time.

You or your office nurse can keep the supplies conveniently available.

##### a) *Reading Material*

First remove all magazines and other reading material.

Then replace with selected material on Americanism.

Pamphlets, leaflets, cartoons, booklets, etc., may be scattered about on tables or shelves.

A magazine or pamphlet rack may be used.

There are many sources for material of this kind. (See below)

One service will keep you supplied with selected material. (See below, No. 8.)

##### b) *Bulletin Board or Display Frame*

A piece of wall board may be framed by your local builder's supply company, or a picture framing establishment.

Post timely cartoons, pictures, clippings, etc.

You can clip these out of magazines or papers, or you may use material from many sources. (See below.)

##### c) *Writing Table*

Keep writing paper and plain envelopes on a table.

Post a notice above,—"*Now is a good time to write your Senators and Congressmen.*"

Offer to stamp and post all letters written.

The bulletin board may be used to post current legislative problems that might prompt letters to legislators.

## 2. THE DOCTOR'S OFFICE

An extra minute's talk with each patient is good public relations and can be used to direct their attention.

- a) *Give each patient something to take home.*

A pamphlet, or a card with some timely slogan.

Some use cards with the names and addresses of Senators and Congressmen.

One doctor (F. W. Dunn, of Muncie) has designed a set of cards for this purpose.

- b) *Start each day with some topic for discussion.*

Be prepared each day with something to discuss with each patient.

This may be the current cartoon on the bulletin board.

It should point toward some element of Americanism, free enterprise, good government, etc.

A clipping from the morning paper may be used.

Keep a few clippings ahead, or have a file of them, so that you will always have one or two handy.

## 3. ORGANIZATION AFFILIATIONS

The physician may not have time to do more than *one* of the above, but *one* is better than *nothing*.

However, he can join and support one or more of the various organizations which are working for better understanding of Americanism, better government, exposure of socialism.

A few of these active organizations are listed below—there are many others.

This is a partial list of organizations which will be glad to have your help in supporting Americanism and fighting the trend toward socialism and the welfare state.

All of these organizations are ready sources of material for your waiting room, for the bulletin board, and for your daily supply of "Ammunition."

A post card to each will bring a prompt reply.

1. *Indiana State Medical Association* Office, 1021 Hume Mansur Building, Indianapolis, 4.

Your state office will keep you posted on many of the latest publications and supplies suitable for your waiting room. Much of this material is free.

2. *American Medical Association*, 535 North Dearborn, Chicago 10, Illinois.

3. *Chamber of Commerce*: Local, State and National, Indiana State Chamber of Commerce, Board of Trade Building, Indianapolis 4.

4. *National Council for American Education*, 1 Maiden Lane, New York 38, New York.

5. *The Association of American Physicians and Surgeons*, 360 North Michigan, Chicago, Illinois.

6. *The Foundation for Economic Education*, Irvington-on-Hudson, New York.

7. *National Doctors Committee for Improved Federal Medical Service*, 15 West 46th Street, New York 19, New York.

8. *The National Research Bureau, Inc.*, 424 North Third Street, Burlington, Iowa.

9. *The Harding College National Education Program*, Searcy, Arkansas.

10. *National Republic*, Publishing Company, 511 Eleventh Street, N.W., Washington 4, D. C.

11. *Committee for Constitutional Government*, 205 East 24th Street, New York 17, New York.

12. *American Progress Foundation*, 808



North Highland Avenue, Los Angeles 38, California.

13. *The Shearon Legislative Service*, 9127 Jones Mill Road, Chevy Chase 15, Maryland.
14. *Republic Steel*, Republic Building, Cleveland 1, Ohio.
15. *United States Steel Corp.*, 71 Broadway, New York 6, New York.
16. *National Association of Manufacturers*, 231 South LaSalle Street, Chicago 4, Illinois.

Watch magazines for advertisements about Americanism. Clip these advertisements for the bulletin board. Some of the advertisers will send free material for distribution and posting in your waiting room.

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James L. Doenges, M.D. (Anderson):

It is very difficult to plan a discussion on a paper given by such an illustrious essayist as Doctor McCormick, without seeing a copy of the paper. However, in this case it is a great pleasure to attempt to discuss certain points in view of the fact that the presentation of Doctor McCormick was singularly outstanding in being a clear enunciation of certain principles with which I am certain we all agree.

Doctor Montgomery has given a very definite plan which, if followed, will result in enormous success. It must be emphasized that everything stated by Doctor McCormick and outlined by Doctor Montgomery will come to nothing unless each individual doctor takes it upon himself to become actively engaged in the process of disseminating sound information, and unless he cooperates with other doctors and individuals in his community to support these processes.

One of the most important steps that can be taken by the county unit or any unit above the individual practitioner is the establishment of definite policies in which the doctors comprising the society believe. It has been stated that "God hates a coward." Originally this was used to describe revulsion to physical cowardice. I believe it is more applicable to a moral coward than to any other individual. In our County Society, the

doctors determined that it would be wise to establish a "Statement of Policy," setting forth the things in which we believe and enumerating those in which we do not believe. This enables all the individuals to know where we stand and to know whether or not we intend to be counted on all-important issues.

Shortly after the founding of the committee in Madison County, a Statement of Policy was prepared and was brought up for discussion before a special meeting of the County Society. Every doctor present expressed his opinion of each and every one of the provisions as set forth. After a very lengthy discussion, the policy was adopted and was signed by every actively practicing physician in Madison County. The policy was publicized through the newspapers as well as by personal communication with our individual patients. This has enabled every citizen who is interested to know exactly the principles on which the doctors in this county agree, and has let him know that he can expect support in sponsoring such principles from his own doctor, as well as the County Society.

The committee was instructed to govern all its activities by that Statement of Policy and it has functioned under this instruction since 1949. Such a plan enables the committee to save the individual doctor an enormous amount of time which the committee members spend in reading bills, studying pamphlets and other forms of literature which are reviewed at regular intervals. The committee studies material which it feels can be used through the doctors' offices, as outlined by Doctor Montgomery. When a presentation of a problem is found which agrees with the Statement of Policy, and which encourages a better understanding of the overall problems of individual freedom and liberty, the committee obtains sufficient numbers of these publications for use in the offices. We believe we have a very unique situation, for the committee is authorized to secure or prepare such materials, and is assured that the County Society will reimburse the committee for its expenditures in carrying out these instructions. As a result, the committee secures thousands of copies of certain publications, whether they be booklets or single page pamphlets. The committee prepares discussions of certain important subjects which are of current interest, and has these mimeographed or printed, for distribution

to individuals and groups. These are all made available to the individual doctors to be used in the office.

Individual members of the County Society also take these publications and papers to their respective Service Clubs for consideration by the members of those groups. In this way, we keep ever before the eyes of our fellow citizens the fact that, as doctors, we are interested in their problems as well as in our own. By doing this, our patients learn that we are interested not only in the maintenance of our freedom, but that we are also vitally interested in, and are working for, the maintenance of their freedom and individual liberty, as well.

We have asked many of these organizations and individuals in days gone by to support us in our fight against regimentation of the practice of medicine. They have responded in a most encouraging manner. By discharging our obligation as citizens, as outlined above, we enter actively into our proper community relationship and again become citizens participating in the maintenance of our community, and of the rights and liberty of every citizen.

Let me emphasize that all of the above will achieve nothing if the individual doctor will not support and actively work for the program in his own office and on every patient-physician contact.

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## INCOME TAX AND REFERRAL FEES

ALBERT STUMP\*

BYRON EMSWILLER

*Indianapolis*

THE purpose of this article is to advise physicians as to the conditions under which they may deduct, as expense items, amounts paid to other physicians out of professional fees which they collect.

The basic income tax law requires that an income tax "be levied, collected, and paid for each taxable year upon the net income of every individual." It provides directions for the computation of net income. An important element in that computation is the question of what may be deducted from the gross income to arrive at the net income. The particular question with which this article deals is governed by Title 26 U. S. Code Annotated, Section 23(a)(1)(A), which reads as follows:

"23. Deductions from gross income. In computing net income there shall be allowed as deductions:

"(a) Expenses.

"(1) Trade or business expenses.

"(A) In general. All the ordinary and necessary expenses paid or incurred during the taxable year in carrying on any trade or business, including a reasonable allowance for salaries or other compensation for personal services actually rendered; traveling expenses (including the entire amount expended for meals and lodging) while away from home in the pursuit of a trade or business; and rentals or other payments required to be made as a condition to the continued use or possession, for purposes of the trade or business, of

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\* Attorney for Indiana State Medical Association.



property to which the taxpayer has not taken or is not taking title or in which he has no equity."

Of course there are many other deductions which do not fall within the classification covered by this subsection. But none of the other subsections are applicable to any element of the question under consideration.

It will be seen from this section that the problem is pinpointed in this question: Are the payments which the physician made to other physicians "ordinary and necessary expenses paid or incurred during the taxable year in carrying on any trade or business"?

To find the answer to that question the two conditions under which the payments may be made must be considered.

**1. Where the physician in charge pays a physician who assists in performing the services.**

The physician who does surgery may have another physician who renders real assistance and aid in the actual performance of the surgery. The physician who renders such actual services, of course, is entitled to compensation for it. If the physician in charge of the operation as the chief surgeon is paid a fee to cover the entire services rendered, including not only his own but also those of the assisting physician, then the chief surgeon is only the collector of that part of the entire fee payable to the assistant. The amount which the surgeon in chief takes from the entire fee and delivers to the assisting physician is earned by the assisting physician for services rendered to the patient. As to that part of the fee payable to the assistant, the chief surgeon does not become the owner himself. He takes that part of the entire fee in trust as an agent of the assistant, for the purpose of delivering it to the assistant. Under such circumstances the chief surgeon should pay no net income tax to the federal government nor any gross income tax to the state government, on the part collected for the assistant.

In order to keep the record clear so that upon an examination of the books by a tax man, or anyone else, the exact truth will be discovered, it is advisable for the physician who has occasion to pay from funds he receives for services to some other physician who assisted in performing

the total service to the patient, to have a special bank account into which he deposits such funds. The special deposit can be designated in any manner the physician may choose, keeping in mind, however, that the designation of the fund might well indicate the nature of it. For instance, Dr. John Doe might have an account entitled "John Doe, M.D., Joint Collection." Then when Doctor Doe performed surgery for which he received a fee of \$150.00 which was to cover also the services of Richard Roe, another physician who assisted him in the surgery, he could deposit that \$150.00 into his "John Doe, Joint Collection" account, and immediately or at his later convenience draw two checks on that account—one to Doctor Roe for, say \$50.00, or whatever the value of Doctor Roe's services would be, and one to himself for whatever remained of that deposit.

By this system the books would make clear the fact that Doctor Doe never treated the entire fee as his own.

Other words that might be added to the name of the doctor to designate such an account might be "Agent" "Trust," or "Trustee." Or it could be designated by an account number, as for instance "John Doe, Account No. —." These are only suggestions. No specific form is required. Physicians may think of better designations.

In this kind of a transaction, of course, each doctor would include in his tax return for both gross and net income only what he received from that deposit, in regard to income in that class.

**2. Where the physician in charge pays money to another physician who performs none of the services for which the fee is collected.**

In this situation a referring physician who performs no service for which a surgeon or other physician to whom the patient was referred makes his charge, the referring physician cannot be said to be receiving money for services rendered. The referring by one physician of a patient to another physician in itself is not the performance of a professional medical service for the patient, according to the rules that have been followed by the tax authorities. Under the code of ethics of the American Medical Association that is fee splitting, and fee splitting is condemned under that code.

If, however, the referring physician has rendered services for which he has not been paid but for which, upon sound ethics, he is entitled to be paid, and if the patient knows that in the fee he is paying to the referred physician is included money to be paid to the referring physician for actual medical services and not merely for the referral—again the referred physician is acting as an agent in collecting that part of the fee which he is ethically bound to pay to the referring physician. And this type of transaction, of course, falls into the first class and should be treated as therein indicated.

One physician may pay another a fee only because he received the referred patient. The physician who makes such payment, under tax authorities, has been held to make a payment not for any ordinary or necessary expense in carrying on his "trade or business." Therefore for a payment of this kind he is not entitled to a deduction.

But what about the physician who received the fee for making the referral but not for any actual professional service rendered? He would be required to report that as one of the receipts of his business. In our opinion he could not treat the receipt of such payments as a gift, even though the physician paying it could not treat it as an ordinary and necessary business expense. The result would be that the referred physician would have to pay gross and net income taxes on the full amount he received, and the referring physician would have to pay both taxes on what he received. The fact that under these circumstances at least part of the payment made by the patient would be taxed twice—once to the referred physician and once to the referring physician, would not prevent the collection of the taxes from both physicians.

### 3. Comments regarding both classes of transactions.

Some confusion was introduced into this tax situation by the decision of the Tax Court of the United States and of the United States Court of Appeals for the Fourth Circuit, in the case

of *Lilly v. Commissioner*. But that case was reversed in the United States Supreme Court on March 10, 1952, in a decision which makes clear the principles upon which we rely in this opinion.

In the *Lilly* case the petitioners were engaged in the optical business. They paid to the doctors who prescribed their eyeglasses one-third of the retail sales prices which they received for the glasses. The Tax Court and the Court of Appeals both held that these payments from the petitioners to the doctors could not be deducted as ordinary and necessary business expenses of the petitioners. But the United States Supreme Court held otherwise.

In the *Lilly* case the evidence showed that there was a nation-wide practice, well established, normal, usual and customary, for optical companies to make these payments to the doctors. The practice was not condemned in the years 1943 and 1944, but was regarded then as ordinary and necessary if an optical company would stay in business. The Court treated as important the fact that the questioned expenditures of the optical companies were not contrary to any "sharply defined national or state policies proscribing particular types of conduct." The opinion also calls attention to the organized activities of the medical profession in dealing with the subject, and in a footnote it states that the present trend "may lead to the complete abolition of the practice." And the opinion indicates that if the present trend continues, then this fact of there having been no sharply defined national or state policy proscribing such conduct in 1943 and 1944 would not longer exist. The opinion makes it clear that if that fact no longer exists, then such expenditures would not be deductible.

In view of the general stand of organized medicine on the ethics of a physician paying another to compensate him only for the referral of cases but not for any medical service rendered, this decision of the Supreme Court, we believe, declares the recognition and approval by that Court of the legal principles upon which we base this opinion.



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Frank M. Hall, M.D., Indianapolis, Director, Division of Services for Crippled Children.  
Miss Louise Griffin, Indianapolis, Director, Children's Division.  
Maurice O. Hunt, Indianapolis, Acting Director of Staff Services.

**DEPARTMENT OF VETERANS AFFAIRS**

16 E. Vermont St.,  
Indianapolis 4

Richard A. McKay, Fort Wayne, Chairman.  
Harold W. Watts, Indianapolis.  
James C. Herod, New Castle.  
Vernon R. McMillan, Terre Haute.

---

Clinton Green, Worthington, Director.  
Orville P. Bray, Indianapolis, Assistant Director and Administrative Officer of World War II Veterans Bonus for the State of Indiana.

**NURSING HOME ADVISORY COUNCIL**

Maurice O. Hunt, Indianapolis, Administrator, State Department of Public Welfare.  
Martha O'Malley, M.D., Indianapolis, Director Division of Hospital and Institutional Services, State Board of Health.  
Alex Houghland, Indianapolis, State Fire Marshal.  
Juul C. Nielsen, M.D., Indianapolis, Medical Director, Indiana Council for Mental Health.

**GOVERNOR'S COMMISSION FOR  
PHYSICALLY HANDICAPPED  
CHILDREN**

Neal E. Baxter, M.D., Chairman, Committee on Maternal and Child Health, Indiana State Medical Association, 306 E. Kirkwood Ave., Bloomington.  
Mr. T. A. Kleckner, Director, Indiana Heart Foundation, Inc., 1101 W. Tenth St., Indianapolis.  
Alan Huckleberry, Ph.D., Director, Special Education and Clinics, Ball State Teachers College, Muncie.  
Mr. Lee L. Eve, Superintendent of City Schools, Crawfordsville.  
Grover L. Hartman, Ph.D., Secretary, Department of Social Service, The Church Federation of Indianapolis, 310 N. Illinois St., Indianapolis 4.

**INDIANA STATE BOARD OF HEALTH**

1330 W. Michigan St.,  
Indianapolis

**Board Members**

J. T. Oliphant, M.D., Farmersburg, Chairman.  
Don E. Bloodgood, B.S.C.E., C.E., Lafayette, Vice-Chairman  
Miss Helen R. Johnson, R.N., Indianapolis.  
Maynard K. Hine, D.D.S., Indianapolis.  
Glenn L. Jenkins, Ph.D., Lafayette.  
R. C. Julien, D.V.M., Flora.  
R. W. Lavengood, M.D., Marion.  
Harry P. Ross, M.D., Richmond.  
James L. Walker, Jr., New Albany.  
Lowell W. Hinchman, D.V.M., Glenwood.  
(Continued)



## (Indiana State Board of Health—Continued)

**Executive Personnel****Administration**

- L. E. Burney, M.D., Secretary and State Health Commissioner.  
M. E. Tennant, Deputy Attorney General.  
Margaret Warner, M.P.H., Director, Division of Personnel and Training.

**Bureau of Central Services**

- Walter J. Strange, Director.  
Maurice L. Allcorn, Director of Personnel.  
Walter J. Strange, Director, Division of Budget and Accounts.  
J. Howard Kurner, Director, Stores and Shipping.

**Bureau of Environmental Sanitation**

- B. A. Poole, Director.  
B. A. Poole, Director, Division of Sanitary Engineering.  
John Taylor, Director, Division of Dairy Products.  
T. E. Sullivan, Director, Division of Food and Drugs.  
Rollin E. Meek, Director, Division of Weights and Measures.

**Bureau of Health Education, Records and Statistics**

- Robert Yoho, Director.  
H. M. Wright, Director, Division of Vital Statistics.  
Verne G. Robinson, Director, Division of Public Health Statistics.  
Robert Yoho, Director, Division of Health and Physical Education.  
T. B. Rice, M.D., Editor of Monthly Bulletin.

**Bureau of Local Health Administration**

- (Vacant), Director.  
Martha O'Malley, M.D., Director, Division of Hospital and Institutional Services.  
Ethel R. Jacobs, R.N., Director, Division of Public Health Nursing.  
William F. Uhl, acting Director, Southeastern Branch Office, Columbus.  
William D. Shillinger, acting Director, Northwestern Branch Office, Valparaiso.  
Max Barrett, acting Director, Northeastern Branch Office, Fort Wayne.  
Harold S. Griswold, acting Director, Southwestern Branch Office, Washington.  
Chester Canham, acting Director, Central Area, Indianapolis.  
James McCoy, Public Health Administrator (Non-medical).

**Bureau of Laboratories**

- Samuel R. Damon, Ph.D., Director.

**Bureau of Preventive Medicine**

- Albert L. Marshall, Jr., M.D., Branch Office Medical Director.  
(Vacant), Director, Division of Tuberculosis Control.  
Roy D. Smiley, D.D.S., Director, Division of Dental Health.  
Louis W. Spolyar, M.D., Director, Division of Industrial Hygiene.  
A. C. Offutt, M.D., Director, Division of Communicable Disease Control including Venereal Disease Control.  
Wendell C. Anderson, M.D., Director, Division of Gerontology and Chronic Diseases.  
Wm. F. King, M.D., Consultant in Gerontology.  
James W. Jackson, M.D., Epidemiologist.

**MEMBERS OF THE ADVISORY COMMITTEE  
TO THE DIVISION OF THE MATERNAL  
AND CHILD HEALTH**

- Bernice Senour, R.N. (temporary charge).  
Neal E. Baxter, M.D., Chairman, 306 E. 5th St., Bloomington.  
G. W. Gustafson, M.D., 23 E. Ohio St., Indianapolis.  
Rex W. Dixon, M.D., 931 Meridian St., Anderson.  
E. R. Carlo, M.D., 2901 Fairfield Ave., Fort Wayne.  
C. O. McCormick, Sr., M.D., 621 Hume Mansur Bldg., Indianapolis.  
H. W. Eggers, M.D., 5231 Hohman Ave., Hammond.  
Carl Huber, M.D., Professor of Obstetrics, Indiana University School of Medicine, Indianapolis.  
Lyman T. Meiks, M.D., Chief Pediatrician, Riley Hospital, Indianapolis.

**INDIANA ADVISORY HEALTH COUNCIL**

- W. Rowland Allen, Indianapolis.  
John V. Barnett, Indianapolis.  
E. Ross Bartley, Bloomington.  
Cleo W. Blackburn, Indianapolis.  
George S. Bond, M.D., Indianapolis.  
Hon. D. Russell Bontrager, Elkhart.  
Paul F. Boston, LaPorte.  
Mrs. Eva R. Brown, Bloomington.  
Mrs. Mary Elizabeth Brown, Carmel.  
J. H. Clevenger, M.D., Muncie.  
Hon. S. Hugh Dillin, St. Petersburg.  
Neal W. Edwards, Indianapolis.  
Mrs. Helen Fargher, Michigan City.  
Roy Fenn, Tell City.  
Lewis S. Finch, Indianapolis.

(Continued)

## (Indiana Advisory Health Council—Continued)

Wray E. Fleming, Indianapolis.  
 Gilbert Forbes, Indianapolis.  
 Eva L. Goble, West Lafayette.  
 Mrs. Caroline Goodwin, Indianapolis.  
 Mrs. Dorothy Greig, Indianapolis.  
 Henry W. Heine, 8 N. Senate Ave., Indianapolis  
 Prof. L. E. Hoffman, West Lafayette.  
 Frank L. Jump, Walton.  
 Chester D. Kelly, Indianapolis.  
 Mrs. Helen Heywood Lewis, Indianapolis.  
 Mrs. Helen McCalment, Indianapolis.  
 Wilbur P. McNulty, D.D.S., Fort Wayne.  
 Carl H. Mullen, Indianapolis.  
 Frank J. Murray, Indianapolis.  
 Mrs. Mildred Neff, Goshen.  
 J. Robert Oldham, D.V.M., Kokomo.  
 Mrs. Genevieve P. Reed, Indianapolis.  
 H. E. Rinne, D.O., Indianapolis.  
 Miss Nancy Scramlin, Indianapolis.  
 Edmund J. Shae, Indianapolis.  
 Mrs. Hazel Steele, Knox.  
 Anson S. Thomas, Indianapolis.  
 Earl M. Utterback, Kokomo.  
 James Waggener, Indianapolis.  
 Mrs. Marjorie H. Walker, Greenfield.  
 Mrs. Marjorie Weaver, Knox.  
 Rollis S. Weesner, Indianapolis.  
 Ralph C. Werner, Indianapolis.  
 J. William Wright, M.D., Indianapolis.  
 Robert H. Wyatt, Indianapolis.

**BOARD OF INDUSTRIAL AID AND  
 VOCATIONAL REHABILITATION  
 FOR THE BLIND  
 536 W. 30th St.,  
 Indianapolis**

**Members of the Board  
 Officers**

Jack Reich, Indianapolis, President.  
 E. O. Snethen, Indianapolis, Vice-President.  
 Mrs. Agnes D. Morris, Princeton, Treasurer.  
 Forrest Chenoweth, Indianapolis, Secretary.

**Administrative Staff**

W. Howard Patrem, Indianapolis, Director.  
 Taylor C. Parker, Chief Rehabilitation Services.  
 C. R. Bird, M.D., Medical Administrative Consultant.  
 K. E. Bratt, Rehabilitation Counsellor.  
 Hazel H. Johnson, Rehabilitation Counsellor.  
 Pearl McGibbons, Rehabilitation Counsellor.  
 Hugh B. McGuire, Placement Agent.  
 J. C. McLain, Placement Agent.  
 Mary E. Cain, Home Teacher and Field Agent.  
 Aletha L. Young, Home Teacher and Field Agent.  
 Elaine Patrem, Home Teacher and Field Agent.  
 Charles M. King, Home Teacher and Field Agent.  
 Eva Herkamp, Home Teacher and Field Agent.

**DIVISION OF VOCATIONAL  
 REHABILITATION  
 INDIANA STATE BOARD OF  
 EDUCATION**

Ort L. Walter, Director, 701 Board of Trade Bldg., Indianapolis.  
 Floyd W. Hammond, Casework Supervisor, 701 Board of Trade Bldg., Indianapolis.  
 Freeman D. Ketron, Guidance, Counseling, and Training, 701 Board of Trade Bldg., Indianapolis.  
 Dr. C. R. Bird, Medical Consultant, 701 Board of Trade Bldg., Indianapolis.  
 Richard M. Phillips, Specialist, Deaf and the Hard of Hearing, 701 Board of Trade Bldg., Indianapolis.  
 Lura Lee Bailey, Counselor, Municipal Bldg., 4th and Broadway, Room 3-B, Gary.  
 Charles O. Campbell, Counselor, School Adm. Bldg., Terre Haute.  
 Lester C. Campbell, Area Supervisor, High School Gymnasium, Bloomington.  
 Homer W. Dutter, Counselor, Northside High School, Fort Wayne.  
 George E. Gill, Counselor, 1512 E. Washington St., Indianapolis.  
 Edward T. Gorman, Counselor, 4811 Magoun Ave., East Chicago.  
 C. D. Hawblitzel, Counselor, 118 N. William St., South Bend.  
 Charles E. McBride, Counselor, High School Gymnasium, Bloomington.  
 John Paul Price, Counselor, 1512 E. Washington St., Indianapolis.  
 Guy E. Russell, Counselor, 504 N. Senate Ave., Indianapolis.  
 Oden Thompson, Counselor, P. O. Box 441, Seymour.  
 John W. Turner, Counselor, Administration Bldg., Ball State Teachers College, Muncie.  
 Floyd T. Walker, Counselor, Woody's Bldg., S. Main, Lapel.  
 Edith J. Crawley, Counselor, School Administration Bldg., Richmond.  
 Thomas L. Wilson, Counselor, Central High School, Room 185, Evansville.  
 George N. Wright, Counselor, Green River Bldg., Purdue University, West Lafayette.



INDIANA DELEGATION IN CONGRESS

UNITED STATES SENATORS\*

Senior Senator—Hon. Homer E. Capehart.  
(R) Washington, Indiana.  
Junior Senator—Hon. William E. Jenner.  
(R) Bedford, Indiana.

\* Address them at Senate Office Building,  
Washington, D. C.

UNITED STATES REPRESENTATIVES†

First District—Hon. Ray J. Madden.  
(D) 578 Broadway, Gary.  
Second District—Hon. Charles A. Halleck.  
(R) Rensselaer.  
Third District—Hon. Shepard J. Crumpacker.  
(R) 1906 Bergan St., South Bend.  
Fourth District—Hon. E. Ross Adair.  
(R) 925 Lincoln Tower, Fort Wayne.

Fifth District—Hon. John V. Beamer.  
(R) 413 N. Miami St., Wabash.  
Sixth District—Mrs. Cecil M. Harden.  
(R) Fifty and Liberty Sts., Covington.  
Seventh District—Hon. William Bray.  
(R) Martinsville.  
Eighth District—Hon. Winfield K. Denton.  
(D) 957 E. Powell Ave., Evansville.  
Ninth District—Hon. Earl Wilson.  
(R) Bedford.  
Tenth District—Hon. Ralph Harvey.  
(R) R. R. 4, New Castle.  
Eleventh District—Hon. Charles B. Brownson.  
(R) 127 E. Washington St., Indianapolis.

† Address them at House Office Building,  
Washington, D. C.

ELECTED STATE OFFICIALS

Office	Incumbent	Poli- tics	Room Number
Governor -----	Henry F. Schricker -----	D	206
Lt. Governor -----	John A. Watkins -----	D	331
Secretary of State -----	Leland L. Smith -----	R	201
Treasurer of State -----	William L. Fortune -----	R	242
Auditor of State -----	Frank T. Millis -----	R	238
Attorney General -----	J. Emmett McManamon -----	D	219
Supt. of Public Instruction -----	Wilbur Young -----	R	227
Clerk of the Supreme Court -----	Thomas C. Williams -----	R	217
Reporter of the Supreme Court -----	Eudora Kelley -----	D	416

LICENSED PRIVATE MENTAL INSTITUTIONS IN INDIANA

Mt. Mercy Sanitarium 1628 Ridge Road Hammond, Indiana	Clearview P.O. Box 837, Kratzville Road Evansville	Wabash Valley Sanitarium Lafayette (temporary license)
Norways Foundation Hospital 1800 East 10th Street Indianapolis	The Retreat (Alcoholic). 41 West 32nd Street Indianapolis	Indiana Home, Inc. 1341 North Alabama Street Indianapolis

INDIANA STATE MENTAL INSTITUTIONS

Central State Hospital Indianapolis C. L. Williams, Supt.	Madison State Hospital North Madison Dr. Claude Lowe, Acting Supt.	Norman M. Beatty Memorial Hospital Westville W. R. VanDenBosch, M.D., Supt.
Evansville State Hospital Evansville Dr. John H. Hare, Supt.	Richmond State Hospital Richmond Dr. Paul D. Williams, Supt.	LaRue D. Carter Memorial Hospital Indianapolis Juul C. Nielsen, M.D., Supt.
Logansport State Hospital Logansport Dr. John A. Larson, Supt.	Ft. Wayne State School Ft. Wayne Mr. Luther T. Hurley, Supt.	Indiana Village for Epileptics New Castle Dr. W. C. Van Nuys, Supt.
	Muscatatuck State School Butlerville Mr. Maurice O'Bannon, Supt.	

# PRESIDENTS OF THE INDIANA STATE MEDICAL ASSOCIATION SINCE ITS ORGANIZATION

Name and Residence	Elected	Served	Name and Residence	Elected	Served
<b>Medical Convention</b>					
*Livingston Dunlap, Indianapolis----	1849	1849	*James H. Ford, Wabash-----	1896	1897
<b>Medical Society</b>			*William N. Wishard, Indianapolis---	1897	1898
*William T. S. Cornett, Versailles----	1849	1850	*John C. Sexton, Rushville-----	1898	1899
*Ashahel Clapp, New Albany-----	1850	1851	*Walker Schell, Terre Haute-----	1899	1900
*George W. Mears, Indianapolis-----	1851	1852	*George W. McCaskey, Ft. Wayne----	1900	1901
*Jeremiah H. Brower, Lawrenceburg--	1852	1853	*Alembert W. Brayton, Indianapolis--	1901	1902
*Elizur H. Deming, Lafayette-----	1853	1854	*John B. Berteling, South Bend-----	1902	1903
*Madison J. Bray, Evansville-----	1854	1855	<b>Medical Association</b>		
*William Lomax, Marion -----	1855	1856	*Jonas Stewart, Anderson-----	1903	1904
*Daniel Meeker, LaPorte-----	1856	1857	*George T. MacCoy, Columbus-----	1904	1905
*Talbot Bullard, Indianapolis-----	1857	1858	*George H. Grant, Richmond-----	1905	1906
*Nathan Johnson, Cambridge City---	1858	1859	*George J. Cook, Indianapolis-----	1906	1907
*David Hutchinson, Mooresville-----	1859	1860	*David C. Peyton, Jeffersonville----	1907	1908
*Benjamin S. Woodworth, Ft. Wayne	1860	1861	*George D. Kahlo, French Lick-----	1908	1909
*Theophilus Parvin, Indianapolis----	1861	1862	*Thomas C. Kennedy, Shelbyville----	1909	1910
*James F. Hibberd, Richmond-----	1862	1863	*Frederick C. Heath, Indianapolis---	1910	1911
*John Sloan, New Albany-----	1863	---	*William F. Howat, Hammond-----	1911	1912
*John Moffett (acting), Rushville----	1863	1864	*A. C. Kimberlin, Indianapolis-----	1912	1913
*Samuel L. Linton, Columbus-----	1864	---	*John P. Salb, Jasper -----	1913	1914
*Wilson Lockhart (acting), Danville--	1864	1865	*Frank B. Wynn, Indianapolis-----	1914	1915
*Myron H. Harding, Lawrenceburg--	1865	1866	*George F. Keiper, Lafayette-----	1915	1916
*Vierling Kersey, Richmond-----	1866	1867	*John H. Oliver, Indianapolis-----	1916	1917
*John S. Bobbs, Indianapolis-----	1867	1868	*Joseph Rilus Eastman, Indianapolis--	1917	1918
*Nathaniel Field, Jeffersonville-----	1868	1869	William H. Stemm, North Vernon---	1918	1919
*George Sutton, Aurora-----	1869	1870	*Charles H. McCully, Logansport----	1919	1920
*Robert N. Todd, Indianapolis-----	1870	1871	*David Ross, Indianapolis-----	1920	1921
*Henry P. Ayres, Ft. Wayne-----	1871	1872	*William R. Davidson, Evansville----	1921	1922
*Joel Pennington, Milton-----	1872	1873	*Charles H. Good, Huntington-----	1922	1923
*Isaac Casselberry, Evansville-----	1873	---	*Samuel E. Earp, Indianapolis-----	1923	1924
*Wilson Hobbs (acting), Knights-			Eldridge M. Shanklin, Hammond-----	1924	1925
town -----	1873	1874	Charles N. Combs, Terre Haute-----	1925	1926
*Richard E. Houghton, Richmond----	1874	1875	*Frank W. Gregor, Indianapolis-----	1926	1927
*John H. Helm, Peru-----	1875	1876	George R. Daniels, Marion-----	1926	1928
*Samuel S. Boyd, Dublin-----	1876	1877	Charles E. Gillespie, Seymour-----	1927	1929
*Luther D. Waterman, Indianapolis--	1877	1878	*Angus C. McDonald, Warsaw-----	1928	1930
*Louis Humphreys, South Bend-----	1878	---	*Alois B. Graham, Indianapolis-----	1929	1931
*Benj. Newland (acting), Bedford			Franklin S. Crockett, Lafayette----	1930	1932
(v.p.) -----	1878	1879	Joseph H. Weinstein, Terre Haute--	1931	1933
*Jacob R. Weist, Richmond-----	1879	1880	*Everett E. Padgett, Indianapolis----	1932	1934
*Thomas B. Harvey, Indianapolis----	1880	1881	*Walter J. Leach, New Albany-----	1933	1935
*Marshall Sexton, Rushville-----	1881	1882	Roscoe L. Sensenich, South Bend---	1934	1936
*William H. Bell, Logansport-----	1882	1883	*Edmund D. Clark, Indianapolis-----	1935	1937
*Samuel E. Mumford, Princeton-----	1883	1884	Herman M. Baker, Evansville-----	1936	1938
*James H. Woodburn, Indianapolis---	1884	1885	*Edmund M. Van Buskirk, Ft. Wayne	1937	1939
*James S. Gregg, Ft. Wayne-----	1885	1886	Karl R. Ruddell, Indianapolis-----	1938	1940
*General W. H. Kemper, Muncie-----	1886	1887	Albert M. Mitchell, Terre Haute---	1939	1941
*Samuel H. Charlton, Seymour-----	1887	1888	Maynard A. Austin, Anderson-----	1940	1942
*William H. Wishard, Indianapolis---	1888	1889	Carl H. McCaskey, Indianapolis-----	1941	1943
*James D. Gatch, Lawrenceburg-----	1889	1890	Jacob T. Oliphant, Farmersburg-----	1942	1944
*Gonsolvo C. Smythe, Greencastle---	1890	1891	Neslen K. Forster, Hammond-----	1943	1945
*Edwin Walker, Evansville-----	1891	1892	Jesse E. Ferrell, Fortville-----	1944	1946
*George F. Beasley, Lafayette-----	1892	1893	Floyd T. Romberger, Lafayette-----	1945	1947
*Charles A. Daugherty, South Bend--	1893	1894	Cleon A. Nafe, Indianapolis-----	1946	1948
*Elijah S. Elder, Indianapolis-----	1894	---	Augustus P. Hauss, New Albany-----	1947	1949
Charles S. Bond (acting), Richmond	1894	1895	C. S. Black, Warren-----	1948	1950
*Miles F. Porter, Ft. Wayne-----	1895	1896	Alfred Ellison, South Bend-----	1949	1951
			J. William Wright, Indianapolis----	1950	1952

\* Deceased.



## APPROVED HOSPITALS IN INDIANA\*

January 1, 1952

**ADAMS COUNTY**

Miss Florence Lichtenstiger, R.N., Adm.  
**Adams County Memorial Hospital.**  
 804 Mercer Ave., Decatur.

**ALLEN COUNTY**

Mr. Donald C. Carner, Adm.  
**Fort Wayne Methodist Hospital, Inc.**  
 119 W. Lewis St., Fort Wayne.  
 O. T. Kidder, M.D., Adm. & Med. Dir.  
**Irene Byron Sanatorium.**  
 R. R. 13, Lima Road North, Fort Wayne  
 Mrs. Margaret Schuh, R.N., Adm.  
**Allen County Isolation Hospital.**  
 R. R. 13, Fort Wayne.  
 Mr. E. C. Moeller, Adm.  
**The Lutheran Hospital of Fort Wayne.**  
 3024 Fairfield Ave., Fort Wayne.  
 Sister M. Augusta, R.N., Adm.  
**St. Joseph Hospital.**  
 730 W. Berry St., Fort Wayne.

**BARTHOLOMEW COUNTY**

Miss Olive M. Murphy, R.N., Adm.  
**Bartholomew County Hospital.**  
 East 17th St., Columbus.

**BLACKFORD COUNTY**

Mrs. Doris M. Wright, Acting Adm.  
**Blackford County Hospital.**  
 503 E. Van Cleve St., Hartford City.

**BOONE COUNTY**

Mrs. Lottie M. Dodson, Adm.  
**Witham Memorial Hospital.**  
 1124 N. Lebanon St., Lebanon.

**CASS COUNTY**

Miss Macie N. Knapp, R.N., Adm.  
**Memorial Hospital.**  
 1101-1115 Michigan Ave., Logansport.  
 Sister Joachime, Adm.  
**St. Joseph Hospital.**  
 26th and North Sts., Logansport.

**CLARK COUNTY**

Mr. William McAlexander, Adm.  
**Clark County Memorial Hospital.**  
 210 Sparks Ave., Jeffersonville.

**CLAY COUNTY**

Miss Helen L. Broughton, R.N., Adm.  
**Clay County Hospital.**  
 1206 E. National Ave., Brazil.

**CLINTON COUNTY**

Miss Maude M. Woodward, R.N., Adm.  
**Clinton County Hospital.**  
 1300 S. Jackson St., Frankfort.

**DAVISS COUNTY**

Mrs. Olive B. DeHart, R.N., Adm.  
**Daviess County Hospital.**  
 1307 Bedford Road, Washington.

**DECATUR COUNTY**

Miss Juliana K. Huser, R.N., Adm.  
**Decatur County Memorial Hospital.**  
 720 N. Lincoln St., Greensburg.

**DEKALB COUNTY**

Bonnell M. Souder, M.D., Adm.  
**Dr. Bonnell M. Souder Hospital.**  
 206 W. 7th St., Auburn.  
 Sister M. Daniela, Adm.  
**Sacred Heart Hospital.**  
 220 S. Ijams St., Garrett.  
 Jesse A. Sanders, M.D., Adm.  
**Sanders General Hospital.**  
 1007 S. Main St., Auburn.

**DELAWARE COUNTY**

Miss Nellie G. Brown, R.N., Adm.  
**Ball Memorial Hospital.**  
 2401 University Ave., Muncie.

**DUBOIS COUNTY**

Sister Mary James, Adm.  
**The Stork Memorial Hospital.**  
 530 4th St., Huntingburg.  
 Mother M. Catherine, Adm.  
**Memorial Hospital of Dubois County.**  
 800 West 9th St., Jasper.

**ELKHART COUNTY**

Mr. Emery K. Zimmerman, Adm.  
**Elkhart General Hospital.**  
 1100 South Boulevard, Elkhart.  
 Mrs. Lois Sinner, Adm.  
**Goshen Hospital.**  
 112-116 N. 5th St., Goshen.

**FAYETTE COUNTY**

Mr. J. W. Myers, Adm.  
**Fayette Memorial Hospital.**  
 1941 Virginia Ave., Connersville.

**FLOYD COUNTY**

Sister M. Joan, R.N., Adm.  
**St. Edward Hospital.**  
 701 E. Spring St., New Albany.  
 J. V. Pace, M.D., Adm.  
**Silvercrest.**  
 (Southern Indiana Tuberculosis Hospital)  
 New Albany.

**FULTON COUNTY**

Miss Bernice I. Rannells, R.N., Adm.  
**Woodlawn Hospital.**  
 624 Pontiac St., Rochester.

**GIBSON COUNTY**

Mrs. Dorothy G. Adams, R.N., Adm.  
**Gibson General Hospital.**  
 419 W. State St., Princeton.  
 R. W. Wood, M.D., Adm.  
**Oakland City Hospital.**  
 211 N. Gibson St., Oakland City.

\* Approved by the Indiana Council for Hospital Licensure and the Indiana State Board of Health.

**GRANT COUNTY**

Miss Amy J. Daniels, Adm.  
Marion General Hospital.  
Wabash and Euclid, Marion.

**GREEN COUNTY**

Mr. Avery Murray, Adm.  
Freeman Greene County Hospital.  
410 "A" St., N.E., Linton.

**HAMILTON COUNTY**

Miss Kittie McKelvey, R.N., Adm.  
Hamilton County Hospital.  
R.R. 4, Noblesville, Ind.

**HANCOCK COUNTY**

Mrs. Nelle M. Lowe, R.N., Adm.  
Hancock County Memorial Hospital.  
800 North Street, Greenfield.

**HARRISON COUNTY**

Miss Anna O'Grady, Adm.  
Harrison County Hospital.  
Corydon.

**HENRY COUNTY**

Mr. Herbert A. Schacht, Adm.  
Henry County Hospital.  
Rural St., New Castle.  
Walter M. Stout, M.D., Adm.  
The Clinic.  
1319 Church St., New Castle.

**HOWARD COUNTY**

Sister M. Louise, R.N., Adm.  
St. Joseph Memorial Hospital.  
1807 W. Sycamore St., Kokomo.

**HUNTINGTON COUNTY**

Miss Maude E. Harlow, R.N., Adm.  
Huntington County Hospital.  
1215 Etna Ave., Huntington.

**JACKSON COUNTY**

Mr. Ralph W. Keyes, Adm.  
Jackson County Schneek Memorial.  
Bruce and Poplar St., Seymour.

**JASPER COUNTY**

Mrs. Ruth Schumaker, R.N., Adm.  
Jasper County Hospital.  
216-224 S. Cullen St., Rensselaer.

**JAY COUNTY**

Mr. Lynn L. Landis, Adm.  
Jay County Hospital.  
505 W. Arch St., Portland.

**JEFFERSON COUNTY**

Mrs. Rinda F. Rains, R.N., Adm.  
King's Daughters' Hospital.  
112 Presbyterian Ave., Madison.

**JOHNSON COUNTY**

Mrs. Ruth L. Raison, R.N., Adm.  
Johnson County Memorial Hospital.  
R.R. 1, Franklin.

**KNOX COUNTY**

Miss Dee Elsome, Adm.  
Good Samaritan Hospital.  
410 S. 7th St., Vincennes.  
R. C. Meyer, M.D., Adm.  
Hillcrest Tuberculosis Hospital.  
North 2nd St. Road, Vincennes.

**KOSCIUSKO COUNTY**

Mrs. Faye O. Downs, R.N., Adm.  
McDonald Hospital.  
Center and Argonne Road, Warsaw.  
Mrs. Samuel C. Murphy, Adm.  
Murphy Medical Center.  
101 W. Winona Ave., Warsaw.

**LAGRANGE COUNTY**

Miss Edythe L. Gappinger, R.N., Adm.  
LaGrange County Hospital.  
LaGrange.

**LAKE COUNTY**

Philip H. Becker, M.D., Adm.  
James O. Parramore Hospital.  
R. R. 5, Crown Point.  
Mr. George R. Wren, Adm.  
The Methodist Hospital of Gary, Inc.  
1600 W. 6th Ave., Gary.  
Sister Mary Reginald, R.N., Adm.  
Mount Mercy Hospital and Sanitarium.  
Lincoln Highway and Joliet St., Dyer.  
Sister M. Vetusa, R.N., Adm.  
St. Catherine Hospital.  
4321 Fir St., East Chicago.  
Sister M. Amelia, R.N., Adm.  
St. Margaret Hospital.  
25 Douglas St., Hammond.  
Sister M. Milburg, R.N., Adm.  
St. Mary Mercy Hospital.  
540 Tyler St., Gary.

**LAPORTE COUNTY**

Mr. Ernest I. Hoover, Adm.  
Fairview Hospital Association, Inc.  
215 Pine Lake Ave., LaPorte.  
H. L. Brooks, M.D., Adm.  
Clinic Hospital.  
125-133 E. 5th St., Michigan City.  
Sister M. Fidelis, R.N., Adm.  
Holy Family Hospital.  
205 "E" St., LaPorte.  
Sister M. Albertinia, R.N., Adm.  
St. Anthony Hospital.  
Wabash and Ann Sts., Michigan City.  
Mr. Stanley E. Giese, Adm.  
Warren Hospital, Inc.  
719 Franklin St., Michigan City.

**LAWRENCE COUNTY**

Mrs. Helen Boyer, R.N., Adm.  
Dunn Memorial Hospital.  
1616 23rd St., Bedford.

**MADISON COUNTY**

Sister Andrea, R.N., Adm.  
Mercy Hospital.  
1331 South "A" St., Elwood.  
Sister M. Margaret Anne, Adm.  
St. John's Hickey Memorial Hospital.  
127 W. 19th St., Anderson.  
Miss Clara M. Lenz, R.N., Adm.  
Citizens Nursing Center.  
431 Citizens Bank, Anderson.



**MARION COUNTY**

Gerald F. Kempf, M.D., Adm.  
**Indianapolis General Hospital.**  
 960 Locke St., Indianapolis.  
 Mr. J. B. H. Martin, Adm.  
**James Whitcomb Riley Hospital for Children.**  
 I. U. Medical Center, 1040-1232 W. Michigan St., Indianapolis.  
 Mr. Robert E. Neff, Adm.  
**Methodist Hospital of Indiana, Inc.**  
 1604 N. Capitol Ave., Indianapolis.  
 Mr. J. B. H. Martin, Adm.  
**Robert W. Long Hospital.**  
 I. U. Medical Center, 1040-1232 W. Michigan St., Indianapolis.  
 Very Rev. August R. Fussenegger, Adm.  
**St. Elizabeth's Maternity Hospital and Infant Home.**  
 2500 Churchman Ave., Indianapolis.  
 Sister M. Alexia, Adm.  
**St. Francis Hospital.**  
 Sherman Drive and Troy Ave., Beech Grove.  
 Sister Lydia, Adm.  
**St. Vincent's Hospital.**  
 120 W. Fall Creek Parkway, Indianapolis.  
 Mrs. Ruth Henderson, Adm.  
**Suemma Coleman Home.**  
 2044 N. Illinois St., Indianapolis.  
 Frank L. Jennings, M.D., Adm.  
**Marion County Tuberculosis Hospital.**  
 Sunnyside Sanatorium, R.R. 12, Box 233, Indianapolis.  
 Mr. J. B. H. Martin, Adm.  
**William H. Coleman Hospital for Women.**  
 I.U. Medical Center, 1040-1232 W. Michigan St., Indianapolis.

**MARSHALL COUNTY**

Miss Mary C. Wass, Adm.  
**Community Hospital of German Township, Inc.**  
 411 Grant St., Bremen.  
 Miss Lela Diefenbaugh, R.N., Adm.  
**Parkview Hospital.**  
 1401 N. Michigan St., Plymouth.

**MIAMI COUNTY**

Mr. William Joy, Adm.  
**Dukes-Miami County Hospital.**  
 12th and Grant Sts., Peru.  
 Mr. W. E. Gollings, Adm.  
**Wabash Employees Hospital Association.**  
 North Broadway, Peru.

**MONROE COUNTY**

Miss Anna G. Nelson, Adm.  
**Bloomington Hospital.**  
 640 S. Rogers St., Bloomington.

**MONTGOMERY COUNTY**

Mr. Ralph M. Haas, Adm.  
**Montgomery County Culver Union Hospital.**  
 308 Binford St., Crawfordsville.

**MORGAN COUNTY**

K. E. Comer, M.D., Adm.  
**Comer Sanitarium.**  
 130 N. Indiana St., Mooresville.  
 Mrs. Crystal L. LaBonte, R.N., Adm.  
**Morgan County Memorial Hospital.**  
 190 S. Main St., Martinsville.

**NOBLE COUNTY**

Harold A. Luckey, M.D., Adm.  
**Luckey Hospital.**  
 Wolflake.  
 Sister M. Joseph, Adm.  
**Kneipp Springs Sanatorium.**  
 Rome City.  
 Mrs. Beulah J. Burns, R.N., Adm.  
**McCray Memorial Hospital.**  
 Hospital Drive, Kendallville.

**ORANGE COUNTY**

Ivan A. Clark, M.D., Adm.  
**Clark Hospital, Inc.**  
 308 E. Main St., Paoli.

**PARKE COUNTY**

Robert A. Staff, M.D., Adm.  
**Indiana State Sanatorium.**  
 R.R. 1, Rockville.

**PERRY COUNTY**

Mrs. Pauline Churchill, Adm.  
**Perry County Memorial Hospital.**  
 Star Route, Tell City, Ind.

**PORTER COUNTY**

Mr. R. Edwin Hawkins, Adm.  
**Porter Memorial Hospital.**  
 814 LaPorte Ave., Valparaiso.

**PULASKI COUNTY**

Thomas E. Carneal, M.D., Adm.\*  
**Carneal's Private Hospital.**  
 111 N. Monticello St., Winamac.

**PUTNAM COUNTY**

Miss Mary Catherine Finn, R.N., Adm.  
**Putnam County Hospital.**  
 322 Greenwood Ave., Greencastle.

**RANDOLPH COUNTY**

Mr. Vernon W. Hyer, Adm.  
**Randolph County Hospital.**  
 Oak Street, Winchester.  
 Mrs. Marcella Kantner, R.N., Adm.  
**Union City Hospital.**  
 702 W. Division St., Union City.

**RIPLEY COUNTY**

Sister M. Gerard, R.N., Adm.  
**Margaret Mary Hospital.**  
 Rosemont Division, Batesville.  
 William J. Warn, M.D., Adm.\*  
**The Whitlatch Clinic and Hospital, Inc.**  
 Milan.

**RUSH COUNTY**

Mrs. Lena Mae Kester, R.N., Adm.  
**Rush Memorial Hospital.**  
 Main at 13th St., Rushville.

\* License pending until certain noncompliances are met.

**SCOTT COUNTY**

Floyd S. Napper, M.D., Adm.  
Napper Hospital.  
69 Wardell St., Scottsburg.

**SHELBY COUNTY**

Mrs. Frances Pruitt, R.N., Adm.  
William S. Major Hospital.  
150 W. Washington St., Shelbyville.

**ST. JOSEPH COUNTY**

E. W. Custer, M.D., Adm.  
Healthwin Hospital.  
1111 West Darden Road, South Bend.  
Mr. Alvan A. Sauer, Adm.  
Northern Indiana Children's Hospital.  
1234 N. Notre Dame Ave., South Bend.  
Mr. Richard W. Trenkner, Adm.  
Memorial Hospital of South Bend.  
604 N. Main St., South Bend.  
Sister M. Reginalda, R.N., Adm.  
St. Joseph Hospital.  
1215 W. 4th St., Mishawaka.  
Sister Miriam Dolores, R.N., Adm.  
St. Joseph's Hospital.  
401 N. Notre Dame Ave., South Bend.  
A. F. Kull, D.O., Adm.  
South Bend Osteopathic Hospital.  
118 S. William St., South Bend.

**STARKE COUNTY**

Miss Thelma Powers, R.N., Adm.  
Starke Memorial Hospital.  
Culver Road, Knox.

**STEUBEN COUNTY**

Mrs. Daisy McCallister, R.N., Adm.  
Cameron Hospitals, Inc.  
416 E. Maumee, Angola.  
Miss Bessie Cottrell, R.N., Adm.  
Elmhurst Hospital, Inc.  
609 W. Maumee, Angola.

**SULLIVAN COUNTY**

Miss Mabel A. Cook, R.N., Adm.  
Mary Sherman Hospital.  
320 N. Section St., Sullivan.

**TIPPECANOE COUNTY**

Mr. T. E. Berg, Adm.  
Lafayette Home Hospital.  
2400 E. South St., Lafayette.  
Sister M. Sponsaria, Adm.  
St. Elizabeth Hospital.  
1021 N. 14th St., Lafayette.  
J. W. Strayer, M.D., Adm.  
William Ross Sanatorium.  
R.R. 6, State Road No. 52, Lafayette.

**TIPTON COUNTY**

Mr. Harry L. Gable, Adm.  
Tipton County Memorial Hospital.  
South Main Street, Tipton.

**VANDEBURGH COUNTY**

Paul D. Crimm, M.D., Adm.  
Boehne Tuberculosis Hospital.  
Upper Mount Vernon Road, Zone 12, Evansville.

Albert G. Hahn, L.H.D., Adm.  
Protestant Deaconess Hospital.  
600-700 Mary St., Evansville.  
Sister Justina, Adm.

St. Mary's Hospital, Inc.  
713 First Ave., Evansville.

Mr. Crayton E. Mann, Adm.  
Welborn Memorial Baptist Hospital, Inc.  
412 S.E. 4th St., Evansville.

**VERMILLION COUNTY**

Miss Hannah Rosser, R.N., Adm.  
Vermillion County Hospital.  
800 S. Main St., Clinton.

**VIGO COUNTY**

Mrs. Arlie L. Dwyer, R.N., Adm.  
Florence Crittendon Home and Hospital.  
1923 Poplar St., Terre Haute.  
J. J. Hoover, M.D., Adm.  
Hoover Sanatorium.  
2144 8th Ave., Terre Haute.  
Sister M. Ludolpha, Adm.  
St. Anthony Hospital.  
1021 S. 6th St., Terre Haute.  
I. Herman Sloss, M.D., Adm.  
Sloss Hospital.  
1029 S. 7th St., Terre Haute.  
Mr. Frank R. Briggs, Adm.  
Union Hospital, Inc.  
7th St. at 8th Ave., Terre Haute.

**WABASH COUNTY**

Mrs. E. A. Ford, Actg. Adm.  
Wabash County Hospital.  
670 N. East St., Wabash.

**WARREN COUNTY**

Mrs. Nellie O. Rudolph, Adm.  
The Community Hospital.  
412 N. Monroe St., Williamsport.

**WASHINGTON COUNTY**

Mr. Frank R. Elrod, Adm.  
Washington County Memorial Hospital.  
Shelby Street, Salem.

**WAYNE COUNTY**

Mr. Frank G. Sheffler, Adm.  
Reid Memorial Hospital.  
Spring Grove, Richmond.  
J. Nelson Ewbank, M.D., Adm.  
Smith Esteb Memorial Hospital.  
R. R. No. 4, Liberty Pike, Richmond.

**WELLS COUNTY**

Mrs. Eileen Stipp, Adm.  
Clinic Hospital.  
309 S. Main St., Bluffton.  
Mrs. Clara Steiner, Adm.  
Wells County Hospital.  
1116 S. Main St., Bluffton.

**WHITLEY COUNTY**

Mr. Carl F. Arnston, Adm.  
Memorial Hospital.  
215 E. Van Buren St., Columbia City.  
Mr. Ralph E. Lyons, Adm.  
Whitley County Memorial Hospital.  
353 N. Oak St., Columbia City.



## ACCREDITED SCHOOLS OF NURSING

April, 1952

School of Nursing and Hospital, University or College with which School is connected		Location	Director, School of Nursing	Daily Patient Census
*a	St. John's Hickey Memorial	Anderson	Sister Anne Miriam, R.N.	206
	Protestant Deaconess	Evansville	Miss Elsie Norman, R.N.	238.8
	St. Mary's	Evansville	Sister Georgiana, R.N.	154.5
	Welborn Memorial Baptist	Evansville	Mrs. Madeline T. Kinney, R.N.	114
a	Lutheran	Fort Wayne	Miss Myrtle E. Lewis, R.N.	200
	Methodist	Fort Wayne	Miss Marie Kolter, R.N.	110
	St. Joseph	Fort Wayne	Sister M. Theodorita, R.N.	255.5
	Methodist	Gary	Miss Marcia J. Aitkens, R.N.	242
	St. Mary Mercy	Gary	Sister M. Cormelia, R.N.	212
xxx	b Goshen College	Goshen	Miss Orpah B. Mosemann, R.N., Act'g.	
	St. Margaret	Hammond	Sister M. Florianne, R.N.	238
a	Indiana University	Indianapolis	Miss Jean L. Coffey, R.N.	536
a	Indianapolis General	Indianapolis	Miss Elizabeth C. Wivel, R.N.	562
b	Methodist	Indianapolis	Miss Fredericka E. Koch, R.N.	637.5
	St. Vincent's	Indianapolis	Sister Clare, R.N.	318
*a	Good Samaritan School,			
	St. Joseph Memorial Hospital	Kokomo	Sister M. Bernadette, R.N.	140
	Lafayette Home	Lafayette	Miss Lucille H. Johnson, R.N.	111.4
a	St. Elizabeth	Lafayette	Sister M. Florina, R.N.	224
	Ball Memorial	Muncie	Miss Clara May Miller, R.N.	265.5
a	Holy Cross Central School	Notre Dame	Sister M. Amadeo, R.N.	
	Hospital Units:			
	St. John's Hickey Memorial			
	Hospital	Anderson		206
	St. Joseph Hospital	Kokomo		140
	St. Joseph Hospital	South Bend		144
	St. Mary's Hospital	Cairo, Illinois		65
	Our Saviour's Hospital	Jacksonville, Illinois		76
xxxa	St. Mary's College	Notre Dame	Sister M. Amadeo, R.N.	
	Reid Memorial	Richmond	Miss Prudence Appelman, R.N.	138
	Memorial Hospital	South Bend	Miss Florence Young, R.N.	202
*a	St. Joseph's	South Bend	Sister M. Cecilian, R.N.	144
a	St. Anthony	Terre Haute	Sister M. Delphina, R.N.	156
	Union	Terre Haute	Miss Ellen R. Church, R.N.	158
	Good Samaritan	Vincennes	Mrs. Zilpha Miller Burnett, R.N.	190

a Negro students are enrolled.

b will accept male students.

\* students are admitted through Holy Cross Central School.

xxx collegiate school of nursing.

## LICENSED NURSING HOMES IN INDIANA

(As of May 8, 1952)

**ADAMS COUNTY**

**Berne Nursing Home**  
906 W. Main St., Berne  
Walter and Maxine Winchester,  
R.N.

**ALLEN COUNTY**

**Colonial Nursing Home**  
802 W. Berry St., Fort Wayne  
Miss Inez Gross, R.N.  
**Crater Nursing Home**  
1407 E. Wayne St., Fort Wayne  
Mrs. Pearl Crater  
"Crow's Haven"  
2440 Bowser St., Fort Wayne  
Mrs. Meta Crow  
**Grace Convalescent Home**  
1529 California Ave., Fort  
Wayne  
Mrs. Jessie G. Richer  
**Lawton Nursing Home**  
1649 Spy Run Ave., Fort Wayne  
Mr. Walter C. Buuck  
**Leslee Home**  
909 Lake Ave., Fort Wayne  
Mrs. Lester Hollmann  
**Munson Home**  
336 Madison St., Fort Wayne  
Mrs. Mabel Munson  
**Twin Maples Sanitarium**  
734 W. Washington Blvd., Fort  
Wayne  
Mrs. Maude M. Cole, R.N.  
**Yerrick Home for Men**  
516 W. Third St., Fort Wayne  
Mrs. Gladys Yerrick

**BARTHOLOMEW COUNTY**

**Brown Nursing Home**  
318 Smith St., Columbus  
Mr. Ithamer Brown  
**Columbus Nursing Home**  
213 Fourth St., Columbus  
Mrs. Lorene Graham  
**Redman's Sanitarium**  
R. R. 4, Columbus  
Frank A. and Nellie D. Redman

**BENTON COUNTY**

**Neal Nursing Home**  
3rd and Maple Sts., Earl Park  
Mrs. Genevieve L. Neal  
**Ellsworth Nursing Home**  
Smith St., Oxford  
Mrs. Bertha Ellsworth

**BLACKFORD COUNTY**

**Anderson Nursing Home**  
134 W. Green St., Montpelier  
Mrs. Cora N. Anderson

**Jackson Convalescent Home**  
423 S. Main St., Montpelier  
Rolland W. Jackson

**BOONE COUNTY**

**Cora's Nursing Home**  
121-123 S. East St., Lebanon  
Mrs. Cora Nelson  
**English Nursing Home**  
304 W. Washington St., Lebanon  
Mrs. Bessie M. English  
**Trammel Nursing Home**  
415 N. Clark St., Lebanon  
Mrs. Sarah S. Trammel  
**Davis Nursing Home**  
310 W. Main St., Thorntown  
Mrs. Ruth Davis  
**Schwinn Nursing Home**  
214 S. Pearl St., Thorntown  
Mrs. Pansy Schwinn  
**Fultz Nursing Home**  
40 N. Third St., Zionsville  
Mrs. Bertha Fultz

**CARROLL COUNTY**

**Good Will Nursing Home**  
Corner Main and Monroe Sts.,  
Camden  
Miss Mabel E. Bechdolt  
**Cornell Nursing Home**  
R. R. 1, Cutler  
Mrs. Victoria Cornell  
**Porter Nursing Home**  
616 E. Monroe St., Delphi  
Mrs. Alsie J. Porter  
**The Arzula Flora Nursing Home**  
312 W. Main St., Flora  
Miss Ida Arzula Flora  
**Mamie Kennedy Nursing Home**  
404 S. Center St., Flora  
Mrs. Mamie Kennedy

**CASS COUNTY**

**Effie Bell Nursing Home**  
R. R. 2, W. Jackson, Galveston  
Mrs. Effie Bell  
**Galveston Nursing Home**  
Washington & Sycamore Sts.,  
Galveston  
Estie and Ednabelle Bell  
**Huffman Nursing Home**  
2533 E. Broadway, Logansport  
Mrs. Honour Ruth Huffman  
**Justice Nursing Home**  
227 Cliff Dr., Logansport  
Mr. and Mrs. Martin Justice

**Rest Haven Nursing Home**  
731 North St., Logansport  
Miss Olive S. Jones  
**Rose Lawn Home**  
3026 E. Broadway, Logansport  
Miss Marie Wilsie Thomas  
**Bird's Home**  
R. R. 2, Royal Center  
Mrs. Irene Bird  
**Flo Dodd Nursing Home**  
Royal Center  
Mrs. Flo Dodd

**CLARK COUNTY**

**Griggs Nursing Home**  
208 W. Riverside Dr., Jefferson-  
ville  
Mrs. Mary C. Griggs  
**Jeffersonville Rest Haven**  
1315 N. Spring St., Jeffersonville  
Mrs. Sarah Roy  
**Keller Home**  
403 E. 7th St., Jeffersonville  
Mrs. Florence Keller

**CLAY COUNTY**

**Brazil Rest Home**  
525 E. Mechanic St., Brazil  
Mrs. James Garvin  
**Dove Dell Rest Home**  
36 N. Forest St., Clay City  
Mrs. Josephine Lowe

**CLINTON COUNTY**

**Colfax Nursing Home**  
P.O. Box 826, Main St., Colfax  
Mrs. Francis M. Waggoner  
**Ashley Nursing & Convalescent  
Home**  
R. R. 6, Frankfort  
Mrs. Jean Ashley Hladik  
**McKinsey Nursing Home**  
407 E. Walnut St., Frankfort  
Mrs. Jane McKinsey, R.N.  
**Harriet Ann Stoker Nursing  
Home**  
R. R. 4, Frankfort  
Mrs. Harriet Ann Stoker

**DAVISS COUNTY**

**Baker's Nursing Home**  
819 Axtell Ave., Washington  
Mrs. Rose Ann Baker  
**Colvin's Nursing Home**  
1109 National Highway,  
Washington  
Mrs. Laura Colvin  
**Meyers Nursing Home**  
215 W. Oak St., Washington  
Mrs. John Meyers



**DEARBORN COUNTY**

Voshell Nursing Home  
R. R. 1, Aurora  
Mrs. Purnell Voshell

**DECATUR COUNTY**

The Black Nursing Home  
619 W. Main St., Greensburg  
Mrs. Pearl Black  
Davis Nursing Home  
510 W. Washington St.,  
Greensburg  
Mrs. Edith Davis  
Michigan Hill Nursing Home  
320 S. Michigan Ave.,  
Greensburg  
Mrs. Mary Clifton  
Sherman Nursing Home  
P.O. Box 123, Westport  
Mrs. Norma Byrum

**DEKALB COUNTY**

Brouse Nursing Home  
R. R. 2, Butler  
W. H. and Susie M. Brouse  
Williams Convalescent Home  
402 N. Broadway, Butler  
R. E. and Pauline Williams  
Williams Nursing Home #2  
610 S. Broadway, Butler  
R. E. and Pauline Williams  
Garrett Convalescent Home  
611 S. Peters St., Garrett  
Mr. and Mrs. Earle R. Saffen

**DELAWARE COUNTY**

Arlis Clark Nursing Home  
South St., Eaton  
Mrs. Arlis R. Clark  
Morgan Nursing Home  
1408 E. Main St., Muncie  
Mrs. Rue Ann Morgan and  
Mrs. Lucy Mae Morgan  
Ring Home  
R. R. 7, Muncie  
Mrs. Elizabeth Ring  
Shady Haven Rest Home  
R. R. 6, Muncie  
Mrs. Leila C. Wilcox  
Sylvester Home for the Aged  
R. R. 5, Burlington Dr., Muncie  
Mrs. Nellie V. Sylvester, R.N.  
Williams Nursing Home  
1525 S. Monroe St., Muncie  
Mrs. Rena Williams  
Woodland Home  
917 E. Main St., Muncie  
Mrs. Hazel Wilson, R.N.  
Karcher Home  
Selma  
Mrs. Aida Karcher

**ELKHART COUNTY**

Hope Convalescent Home  
E. Vistula St., Bristol  
Mrs. Bernice Alverson  
Cora Shaum Nursing Home  
901 S. Second St., Elkhart  
Mrs. Cora Shaum  
Thorp Nursing Home  
115 Washington St., Elkhart  
Mrs. Ruth G. Thorp  
The Austin Home  
526 N. Sixth St., Goshen  
Mr. and Mrs. Fred S. Austin  
Coil Convalescent Home  
225 S. 5th St., Goshen  
Mrs. Wilma L. Coil  
Holm Convalescent Home  
807 N. Main St., Goshen  
Mrs. Goldie Holm Rogers  
Lockerbie Nursing Home  
302 E. Lincoln Ave., Goshen  
Mrs. Bertha J. K. Lockerbie  
Weaver Convalescent Home  
R. R. 5, Goshen  
Mrs. Esther Weaver  
Lee Nursing Home  
318 Beardsley Ave., Elkhart  
Mrs. Nellie R. Lee

**FAYETTE COUNTY**

Lincoln Manor  
903 Lincoln Ave., Connersville  
Mr. Chester O'Neal

**FOUNTAIN COUNTY**

Maplewood Nursing Home  
R. R. 4, Veedersburg  
Mrs. Mable Butte and  
Mrs. Maxine Brown

**FRANKLIN COUNTY**

The Resthaven Reifel Nursing Home  
1015 Franklin St., Brookville  
Mrs. Elizabeth A. Reifel

**FULTON COUNTY**

McFarland Nursing Home  
816 Jefferson St., Rochester  
Mrs. Ralph McFarland  
Rochester Nursing Home  
719 Madison St., Rochester  
Mr. Gerald Eastburg

**GIBSON COUNTY**

Church Convalescent Home  
417 W. Broadway, Princeton  
Mrs. Edra E. Church  
Sunny Side  
314 N. West St., Princeton  
Mrs. Sylva Claspell  
Hitch Convalescent Home  
Patoka  
Mrs. Ethel M. Hitch

**GRANT COUNTY**

Bide-A-Wee Rest Home  
910 N. Rush St., Fairmount  
Mrs. Agnes Butcher  
Jackson Nursing Home  
R. R. 2, Fairmount  
Mrs. Maude J. Jackson  
The Roberts Nursing Home  
P.O. Box 102, Fowlerton  
Mrs. Ethel Roberts  
Darr's Convalescent Home  
702 E. 26th St., Marion  
Mrs. Maude L. Darr  
Frances' Nursing Home  
1827 S. Adams St., Marion  
Mrs. Frances Moore  
Mrs. Lanter's Home  
1649 W. Second St., Marion  
Mrs. Anna Lanter  
Whiteman Nursing Home  
148 N. Branson St., Marion  
Mrs. B. E. Whiteman  
Campbell Nursing Home  
Box 53, Van Buren  
Mrs. Bertha O. Campbell

**HAMILTON COUNTY**

Arcadia Rest Home  
S. School St., Arcadia  
Mrs. Florence Sigler  
Moore's Nursing Home  
South St., Arcadia  
Mrs. Anna Moore

**HANCOCK COUNTY**

Siders Home  
124 E. Osage St., Greenfield  
Mrs. Elizabeth Siders  
Wood's Nursing Home  
14 N. Wood St., Greenfield  
Mrs. Hazel E. Wood  
Pleasant Acres  
R. R. 12, Box 320, Indianapolis  
Corner 56th & McCordsville Rd.  
Mr. Frederick M. Burns

**HENDRICKS COUNTY**

Plainfield Nursing Home  
404 N. Vine St., Plainfield  
Miss Lois B. Thompson  
Perkins Nursing Home  
64 N. Hight St., Danville  
Mrs. Pearl Perkins

**HENRY COUNTY**

"The Boxwoods"  
115 N. 10th St., New Castle  
Mrs. Margaret Harris  
Whitacre Nursing Home  
Spiceland  
Mr. and Mrs. William Whitacre  
Reynolds' Convalescent Home  
Box 157, Spiceland  
Mrs. Adeline Reynolds

**HOWARD COUNTY**

**Colonial Haven Nursing Home**  
613 E. Superior St., Kokomo  
Mrs. Edith N. Tolle

**Restmor Nursing Home**  
420 N. Market St., Kokomo  
John J. and Rogene E. Cooper

**Sunny View Convalescent Home**  
510 N. Market St., Kokomo  
Mrs. Mary Devore

**HUNTINGTON COUNTY**

**Davis Nursing Home**  
207 Frederick St., Huntington  
Mrs. Annette Davis

**DeKoning Convalescent Home**  
R. R. 8, Huntington  
Mrs. Ann Cecilia DeKoning

**Jefferson Sanitarium**  
414 S. Jefferson St., Huntington  
Herbert Earl Atkinson, Sr.

**Moore Home**  
425 Hasty St., Huntington  
Mrs. Maud Moore

**Sears Nursing Home**  
325 S. Jefferson, Huntington  
Mrs. Ethel K. Sears

**Oak Park Sanitarium**  
743 N. Main St., Roanoke  
Mrs. Fern N. Martin

**JACKSON COUNTY**

**Roselawn Home**  
202 W. 6th St., Seymour  
Mrs. Esta T. Martin

**JEFFERSON COUNTY**

**Madison Nursing Home**  
726 W. Main St., Madison  
Mrs. Ella Shuell, R.N.

**Glore Nursing Home**  
North Madison  
Mrs. Flora Glore

**Hilltop Rest Home**  
Box 67, North Madison  
Mrs. Susan Obertate

**Kincaid Nursing Home**  
416 E. Second St., Madison  
Mr. Bertram Joseph Kincaid

**JOHNSON COUNTY**

**Johnson Nursing Home**  
651 S. State St., Franklin  
Mrs. Janie Johnson

**McKee's Nursing Home**  
400 Kentucky St., Franklin  
Mrs. Florence Ellen McKee

**KNOX COUNTY**

**Moore's Nursing Home**  
204 W. Third St., Bicknell  
Mrs. Adeline Bernice Moore

**KOSCIUSKO COUNTY**

**Alfran Nursing Home**  
R. R. 1, Road #30, Pierceton  
Frank N. Wilson and  
Alice M. Wilson, R.N.

**Armington Home**  
519 W. Winona Ave., Warsaw  
Mrs. Charles Armington

**LAGRANGE COUNTY**

**Blick Convalescent Home**  
308-310 S. Detroit St., LaGrange  
Mr. and Mrs. J. A. Blick

**Maplehaven Rest Home**  
Mongo  
Mrs. Betty L. Bennett

**LAKE COUNTY**

**Hilltop Nursing Home**  
R. R. 2, Crown Point  
Mrs. Olive Beggs

**Shady Heights**  
Dyer  
Mrs. Faye McGuire

**Beaton's Nursing Home**  
521 Pennsylvania St., Gary  
Mrs. Laura Beaton

**Calloway's Nursing Home**  
1948 Massachusetts St., Gary  
Mrs. Tomye D. Calloway

**Greens Home**  
3960 Massachusetts St., Gary  
Mrs. Lillian Green

**Miller Nursing Home**  
2301 Adams St., Gary  
Miss Ida Miller

**Sanders Nursing Home**  
1944 Maryland St., Gary  
Mrs. LaGora Sanders

**West End Convalescent Home**  
1501 Wheeler St., Gary  
Mrs. Esther G. Jones

**Hodge Nursing Home**  
909 State St., Hammond  
Mrs. Lucille Hodge

**Lana's Nursing Home**  
726 Sibley St., Hammond  
Mrs. Lana Hodge

**LAPORTE COUNTY**

**White Tower**  
209 State St., LaPorte  
Mrs. Esther Jones

**LAWRENCE COUNTY**

**Kinder Nursing Home**  
618 "I" St., Bedford  
Mrs. Mabel M. Kinder

**Mrs. Estella Norwood Nursing Home**  
916 14th St., Bedford  
Mrs. Estella Norwood

**Stancombe Nursing Home**  
R. R. 5, Bedford  
Clifford and Pearl Stancombe

**The Greenwell Home**  
329 W. Oak St., Mitchell  
Mrs. Florence Greenwell

**MADISON COUNTY**

**Bright Memorial Home**  
2025 Jackson St., Anderson  
Mrs. Blanche Graser

**Goble Home**  
332 W. 11th St., Anderson  
Mr. and Mrs. Oran Goble

**McVey Nursing Home**  
1519 W. 3rd St., Anderson  
Mrs. Stella May McVey

**Pleasant Rest Home**  
1719 Morton St., Anderson  
Mrs. Alta V. Delph Callihan

**Rahbek Nursing Home #1**  
1102 E. Sixth St., Anderson  
Mrs. Marie L. Rahbek

**Rahbek Nursing Home #2  
(For Women)**  
528 Walnut St., Anderson  
Mrs. Marie L. Rahbek

**Sanders Nursing Home**  
1403 Brown St., Anderson  
Mrs. Vera M. Sanders

**Van Dyke Nursing Home**  
2417 Pearl St., Anderson  
Mrs. Pearl M. Van Dyke

**Hughes Nursing Home**  
1624 S. "M" St., Elwood  
Mrs. Effie Hughes

**McGuire Nursing Home**  
2224 S. "K" St., Elwood  
Mrs. Nellie Fern McGuire

**Scott's Nursing Home**  
339 Broadway, Pendleton  
Mrs. Ruby Scott

**MARION COUNTY**

**Tall Cedars**  
R. R. 1, Box 27, Bridgeport  
Mrs. Ora Miley

**Booker's Convalescent Home**  
812 E. 14th St., Indianapolis  
Mrs. Geneva Booker

**Central Nursing Home**  
2262 Central Ave., Indianapolis  
Mrs. Bertha A. Montgomery

**Ethel Christen's Nursing Home**  
1930 Sugar Grove Ave.,  
Indianapolis  
Mrs. Ethel Christen

**Conde Nursing Home**  
624 E. 12th St., Indianapolis  
Marian Niles and  
Beulah Gronlund



**Cottage Rest Home**  
46 S. Warman Ave., Indianapolis  
Mrs. Louise Wooldridge

**Marie Fred Nursing Home**  
604 N. Jefferson Ave.  
Indianapolis  
Mrs. Marie Fred, R.N.

**Higgins Nursing Home**  
1336 Bellfontaine St.,  
Indianapolis  
Mrs. Mollie Richardson

**Hillside Nursing Home**  
2370 Hillside Ave., Indianapolis  
Mrs. Ella Mason

**Hooper Nursing Home**  
1636-38 N. Illinois St.,  
Indianapolis  
Mrs. Carol Hooper

**Huff Sanitarium**  
115 S. Audubon Rd.,  
Indianapolis  
Mrs. Rachel A. and  
Bettina Sullivan

**Hulst Sanatorium**  
333 N. Delaware St.,  
Indianapolis  
Mrs. Mary E. Hulst

**Irvington Sanitarium**  
R. R. 10, Box 320, Indianapolis  
Mrs. Minnie P. Waymire

**Jennings Rest Home**  
942 N. Alabama St., Indianapolis  
George F. and Clara B. Jennings

**King Nursing Home**  
1907 N. Illinois St., Indianapolis  
Mrs. Henrietta Quinn

**Myrtle Lee Nursing Home**  
1429 Carrollton Ave.,  
Indianapolis  
Miss Mabel Cecilia Smalley

**Lou Wise #2**  
2516 Central Ave., Indianapolis  
Mrs. Bessie Craig

**Lucile Nursing Home**  
610 N. Senate Ave., Indianapolis  
Mrs. Lucile Mealure

**Lynhurst Nursing Home #1**  
5225 W. Morris St., Indianapolis  
Mrs. Mabel Waldkoetter

**Lynhurst Nursing Home #2**  
6566 W. Washington St.,  
Indianapolis  
Millard and Gladys Springer

**Martin Nursing Home**  
1621 Park Ave., Indianapolis  
Mrs. Lucille Martin

**Matthews Rest Home**  
823 Broadway, Indianapolis  
Mrs. Ethel M. Matthews

**Maxson Nursing Home**  
842 Broadway, Indianapolis  
Mrs. Helen Maxson

**Messer Nursing Home**  
2432 Central Ave., Indianapolis  
Mary J. and Calvin Messer

**Mohler Sanatorium**  
702-704 N. Alabama St.,  
Indianapolis  
Mrs. Ada Anselm Mohler

**Moye Nursing Home**  
2115 Central Ave., Indianapolis  
Mrs. Agnes Moye

**Olympia Nursing Home**  
6759 E. Washington St.,  
Indianapolis  
Mrs. Frances Limpus

**Pike Sanitarium**  
2037 N. Illinois St., Indianapolis  
Mrs. Lillian G. Pike

**Pleasant View Rest Home**  
5000 Southeastern Ave.,  
Indianapolis  
Mrs. Laura E. Weber

**Rest Haven Sanitarium**  
3245 N. Illinois St., Indianapolis  
Mrs. Carolyn Carden

**Robinson's Private Home #1**  
2254 Central Ave., Indianapolis  
Mrs. Eunice Robinson

**Robinson's Private Home #2**  
2250 Central Ave., Indianapolis  
Mrs. Eunice Robinson

**Rose Lawn Home**  
2835 N. Meridian St.,  
Indianapolis  
Mrs. Lucy V. Connor

**Suddarth Nursing Home**  
1445 Broadway, Indianapolis  
Mrs. Cleo Suddarth

**Sunshine Nursing Home**  
4416 E. Washington St.,  
Indianapolis  
Mrs. Ethel M. Bills

**Vollmer Convalescent Home**  
2630 College Ave., Indianapolis  
Mr. Emory H. Vollmer

**Mrs. Waddle's Private Home**  
2112 N. Delaware St.,  
Indianapolis  
Mrs. Mable S. Waddle

**Ward Nursing Home**  
1518 N. Senate Ave.,  
Indianapolis  
Mrs. Willa Mae Murray

**Weber Convalescing Home**  
43 S. Ritter Ave., Indianapolis  
Mrs. Laura E. Weber

**West Park Home**  
373 N. Holmes Ave.,  
Indianapolis  
Mrs. Mary R. Frame

**Wildwood Restorium**  
895 Middle Dr., Woodruff Place,  
Indianapolis  
Mrs. Nellie Wildman

**MARSHALL COUNTY**

**Bair Convalescent Home**  
801 N. Main St., Bourbon  
Mrs. Kathryn M. Bair, R.N.

**Austin Nursing Home**  
821 Angell St., Plymouth  
Mrs. Mabel M. Austin

**Pearl Street Nursing Home**  
618 Pearl St., Plymouth  
Miss Bertha Mohr and  
Miss Grace Stonehill

**Sherman Nursing Home**  
203 Pennsylvania Ave.,  
Plymouth  
Mrs. Vesta K. Sherman

**MIAMI COUNTY**

**Glen Rest Convalescent Home**  
R. R. 4, Peru  
Mrs. Thelma Woeckener

**Peru Nursing Home**  
906 W. Main St., Peru  
Mrs. Norma Eileen Edson, R.N.

**Redmon Nursing Home**  
225 W. 10th St., Peru  
Mrs. Lola Redmon

**Barnes Nursing Home**  
224 W. 10th St., Peru  
Mrs. Charlotte Barnes

**MONROE COUNTY**

**Henry Home**  
421 W. First St., Bloomington  
Mrs. Gertie Henry

**Parrott Nursing Home**  
115 S. Lincoln St., Bloomington  
Miss Mary Gwendolia Parrott,  
R.N.

**Percifield Nursing Home**  
1031 W. 6th St., Bloomington  
Mr. W. S. Percifield

**Polley Nursing Home**  
705 W. 4th St., Bloomington  
Mrs. Elsie Mae Polley

**Wilkins Nursing Home #1**  
1023 E. 10th St., Bloomington  
Mrs. Orpha Wilkins

**MONTGOMERY COUNTY**

**Hart Memorial Home**  
R. R. 1, Crawfordsville  
Mrs. Myrtle Johnson

**Shahan Nursing Home**  
613 Kentucky St.,  
Crawfordsville  
Miss Eileen M. Shahan

**Hazel Small Rest Home**  
N. Vine St., Waynetown  
Mrs. Hazel Small

**Van Cleave Home**  
614 S. Washington St.,  
Crawfordsville  
Mrs. Clara Van Cleave

**NOBLE COUNTY**

**Brogan Home**  
508 W. Mitchell St., Kendallville  
Mrs. Hilda Brogan

**OHIO COUNTY**

**Galbreath Home**  
Fourth St., Rising Sun  
Mrs. Effie Galbreath

**OWEN COUNTY**

**Gospport Nursing Home**  
W. Main St., Gospport  
Mrs. Mary Wampler  
**Jones Nursing Home**  
379 Hillside Ave., Spencer  
Mr. and Mrs. Boyd Jones  
**Reapp Nursing Home**  
Greencastle Rd., Spencer  
Mrs. Jennie C. Reapp

**PARKE COUNTY**

**Wallace Nursing Home**  
517 W. Ohio St., Rockville  
Mrs. Evelyn Wallace

**PIKE COUNTY**

**Fay's Convalescent Home**  
210 S. 14th St., Petersburg  
Mrs. Fay France  
**Riddle Nursing Home**  
411 Walnut St., Petersburg  
Mrs. Alice M. Riddle

**PORTER COUNTY**

**Wood Home**  
R. R. 2, West Dunes Highway,  
Michigan City  
Mrs. Helen O. Wood  
**Beverly Shores Rest Home**  
Beverly Shores  
Samuel Robert Parker, M.D.

**POSEY COUNTY**

**Allison Nursing Home**  
Locust St., Poseyville  
Mrs. Lula Allison

**PUTNAM COUNTY**

**Ruark Nursing Home**  
R. R. 1, Fillmore  
Mrs. Elsie Cowgill Ruark  
**Craver Home**  
R. R. 3, Greencastle  
Mrs. Hannah Craver  
**Westfall Nursing Home**  
218 Bloomington St.,  
Greencastle  
Mrs. Nina A. Westfall

**Milhon Nursing Home**  
R. R. 1, Fillmore  
Mrs. Malissie E. Milhon  
**Donna Nursing Home**  
416 E. Hanna St., Greencastle  
Mrs. Mildred Brown

**RANDOLPH COUNTY**

**The Ideal Rest Home**  
104 S. Cherry St., Lynn  
Mrs. Blanche E. Allender

**RIPLEY COUNTY**

**The Conyer's Nursing Home**  
Milan  
Mrs. Mary Colson  
**Rick Nursing Home**  
R. R. 1, Milan  
Mrs. Violet Rick  
**Gilland Nursing Home**  
310 Craven St., Osgood  
Mr. and Mrs. Dan Gilland  
**Elsie Dreyer Nursing Home**  
Main St., Sunman  
Miss Elsie Dreyer  
**Mary Dreyer Nursing Home**  
R. R. 1, Sunman  
Mrs. Mary Dreyer

**RUSH COUNTY**

**Clark Nursing Home**  
230 E. 7th St., Rushville  
Mrs. Harry Clark  
**Clifton Nursing Home #1**  
204 W. Third St., Rushville  
Mrs. Mary Clifton  
**Clifton Nursing Home #2**  
R. R. 1, (Circleville), Rushville  
Mrs. Mary Clifton  
**Jackson Nursing Home**  
114 E. 5th St., Rushville  
Mrs. Goldie C. Jackson  
**Rushville Nursing Home**  
321 N. Morgan St., Rushville  
Mrs. Marjorie Fordyce  
**Cohee Rest Home**  
432 W. 1st. St., Rushville  
Mrs. Harvey Cohee

**SHELBY COUNTY**

**Foreman's Nursing Home**  
R. R. 1, Fountaintown  
Mrs. Dorothy Foreman  
**Maples Convalescent Home**  
R. R. 1, Fountaintown  
Mr. and Mrs. William McGraw  
**Land's Nursing Home**  
Morristown  
Ida and Elbert Land

**Smith Nursing Home**  
Waldron  
Mrs. Avonell Smith

**SPENCER COUNTY**

**Mayhall Nursing Home**  
417 S. 6th St., Rockport  
Mrs. Alice R. Mayhall Freshley

**ST. JOSEPH COUNTY**

**Emerick Home**  
910 W. 4th St., Mishawaka  
Mrs. Ila Mae Emerick  
**Krogh Nursing Home**  
109 N. Cedar St., Mishawaka  
Miss Bernalda I. Krogh  
**Dor-A-Lin Convalescent Home**  
1024 N. Notre Dame Ave.,  
South Bend  
Mr. and Mrs. Franklin W.  
Finkenbinder  
**Frame's Nursing Home**  
1526 Lincoln Way West,  
South Bend  
Mrs. Myrtle Frame  
**Gibson Nursing Home**  
1145 Napier St., South Bend  
Mrs. Ola Gibson  
**Vera Jones Nursing Home**  
702 S. Columbia St., South Bend  
Mrs. Vera Jones  
**Kintz's Rest Home**  
1611 South Bend Ave.,  
South Bend  
Mrs. Edith Kintz  
**Morran Nursing Home**  
2617 S. Main St., South Bend  
Helena Elaine Morran  
**Van Rie Nursing Home**  
1044 Lincolnway West,  
South Bend  
Mrs. Frances Van Rie  
**Williams Nursing Home**  
601 N. Main St., South Bend  
Mrs. Fern Grove  
**Waldron Nursing Home**  
500 Roosevelt Rd., Walkerton  
Mrs. Virginia Waldron

**STARKE COUNTY**

**Ruff Nursing Home**  
75 W. Johns St., Knox  
Mrs. Alcinda Ruff

**STEBUEN COUNTY**

**Angola Rest Home**  
306 N. Wayne St., Angola  
Mrs. Ruth Mason and  
Mrs. Olive Guilford  
**Edith Nursing Home**  
116 N. Powers St., Angola  
Mrs. Edith Schmidt



**TIPPECANOE COUNTY****Laura M. Bowles Convalescent Home**

Clarks Hill

Mrs. Laura M. Bowles

**Burnett's**

221 S. 9th St., Lafayette

Mrs. Angie Burnett

**Lewis Nursing Home**

641 New York St., Lafayette

Mrs. Betty Mackey Lewis

**Scott Nursing Home for Men**

614 N. 8th St., Lafayette

Mr. Howard F. Scott

**Scott Nursing Home for Women**

1100 N. 9th St., Lafayette

Mrs. Goldie Scott

**TIPTON COUNTY****Simmons Nursing Home**

325 N. West St., Tipton

Mrs. Ernest Simmons

**UNION COUNTY****Scott Nursing Home**

302 W. Union St., Liberty

Mrs. Anna Scott

**VANDEBURGH COUNTY****Axton's Rest Home**

203 Oakley St., Evansville

Mrs. Maymee M. Axton

**Bethany Rest Home**

316 N. Wabash Ave., Evansville

Mrs. Edith Poole Masterson

**Comfort Rest Home**

811 Southeast 3rd St.,

Evansville

Mrs. Ethel Drake Cowles

**Evans Nursing Home**

605 Oak St., Evansville

Mrs. Anna Evans

**Fulton Rest Home**

1328 N. Fulton Ave., Evansville

Mrs. Grace L. Richter

**Gee's Rest Haven**

807 Southeast 3rd St.,

Evansville

Mrs. Leona Gee

**Jarrett Convalescent Home**

605 Oakley St., Evansville

Mrs. Lena K. Jarrett

**M & R Nursing Home**

1100 N. Read St., Evansville

Mrs. Muriel A. Beumer

**Maxey Nursing Home**

909 First Ave., Evansville

Mr. and Mrs. Pearlless Maxey

**Pleasant Nursing Home**

109 W. Maryland St., Evansville

Mrs. Maryetta Morris

**Ingle Smith Home**

521 S. E. First St., Evansville

Mrs. Della Ingle Smith, R.N.

**Stinson Rest Home**

315 Southeast Second St.,

Evansville

Mrs. Mildred Stinson

**Taylor Nursing Home**

915 W. Bond St., Evansville

Mrs. Juanita Taylor

**Tindall Rest Home**

218 Harriett St., Evansville

Mrs. Dorothy Tindall Pennington

**Ulbricht Rest Home**

616 W. Franklin St., Evansville

Mrs. Martha Ulbricht

**VIGO COUNTY****Cook Nursing Home**

2058 N. 7th St., Terre Haute

Mrs. Grace E. Cook

**Foos Nursing Home**

418 S. 8th St., Terre Haute

Mrs. Lydia E. Foos

**Gano Nursing Home**

501 N. 4th St., Terre Haute

Mrs. Anna Gano

**Hise Nursing Home**

120 N. 12th St., Terre Haute

Mrs. Lillie Hise

**Kesler's Nursing Home**

724 N. 8th St., Terre Haute

Mrs. Clara A. Kesler

**Mary Etta Nursing Home**

1915 N. 11th St., Terre Haute

Mrs. Mamie Mason

**Mrs. Barney Pigg Nursing Home**

1334 Sycamore St.

Terre Haute

Mrs. Barney Pigg

**Rollo Boarding Home for Men**

635 N. 6th St., Terre Haute

Mrs. Myrtle Rollo

**"Sharps"**

1518 N. Center, Terre Haute

Mrs. Hazel M. Sharps

**Doris Standeford Nursing Home**

1103 S. 11½th St., Terre Haute

Miss Doris Standeford

**Sullivan Nursing Home**

705 S. 7th St., Terre Haute

Mrs. Grace F. Sullivan

**WABASH COUNTY****Sincroft Nursing Home**

306 E. 4th St., North Manchester

Mrs. Pearl Sincroft

**Dunfee Nursing Home**

1250 Pike St., Wabash

Mrs. Florence Dunfee

**Moss Nursing Home**

855 Ferry St., Wabash

Mrs. Irene Moss

**WARRICK COUNTY****Hollis Nursing Home**

R. R. 5, Boonville

Mrs. Loraine Hollis

**Hollis Nursing Home #2**

R. R. 5, Boonville

Mrs. Loraine Hollis

**WASHINGTON COUNTY****Shuell Nursing Home #1**

R. R. 1, Scottsburg

Mrs. Ella L. Shuell, R.N.

**Shuell Nursing Home #2**

R. R. 1, Scottsburg

Mrs. Ella L. Shuell, R.N.

**WAYNE COUNTY****Bowman's Rest Home**

444 W. Main St., Cambridge City

Howard and Esther Bowman

**Pinehurst Nursing Home**

R. R. 1, Centerville

Mrs. Gertrude E. Johnson

**Gains Nursing Home #1**

R. R. 2, Box 448, Richmond

Mrs. Emma Gains

**Gains Nursing Home #2**

R. R. 2, Box 448, Richmond

Mrs. Emma Gains

**Jennie Hartman Nursing Home**

139 S. E. 14th St., Richmond

Mrs. Jennie Hartman

**WELLS COUNTY****Davis Nursing Home**

R. R. 3, Bluffton

Mrs. I. Helen Davis

**WHITLEY COUNTY****Farris Nursing Home**

209 W. Market St.,

Columbia City

Mrs. Louise Farris

**Irvin Nursing Home**

604 W. Van Buren St.,

Columbia City

Mrs. Marguerite Irvin

**South Whitley Rest Home, Inc.**

306 Columbia St., South Whitley

Katherine A. and Robert E.

Bresnahan

# COMPENSATION SCHEDULE FOR PARTICULAR RESULTS OF INJURIES

as outlined in Section 31 of yellow-backed pamphlet entitled,

“WORKMEN’S COMPENSATION AND OCCUPATIONAL DISEASES ACTS OF INDIANA AND RULES OF THE INDUSTRIAL BOARD OF INDIANA”

printed, released and dated 1951

## Section 31 (a) (1) AMPUTATIONS:

Loss by separation:

*of Thumb*—60 weeks

1. The loss of *more than one phalange* shall be considered as the loss of *the entire thumb* (60 weeks).
2. The loss of not more than one phalange shall be considered as the loss of *one-half* ( $\frac{1}{2}$ ) of *the entire thumb* (30 weeks).

*of Fingers*—(See Below)

Index finger ----- 40 weeks  
 Second finger ----- 35 weeks  
 Third or Ring finger ----- 30 weeks  
 Fourth or little finger ----- 20 weeks

1. The loss of *more than two phalanges* of a finger shall be considered as the loss of *the entire finger*.
2. The loss of *not more than two phalanges* of a finger shall be considered as the loss of *one-half* ( $\frac{1}{2}$ ) of *the finger*.
3. The loss of *not more than one phalange* of a finger shall be considered as the loss of *one-third* ( $\frac{1}{3}$ ) of *the finger* and compensation shall be paid for one-third the period for the loss of the entire finger.

Combination: (See Below)

When two or more fingers are impaired, as the result of the same injury the percent of permanent partial impairment shall be figured on the entire hand. The following percentage table may be used to figure any combination of injury to the hand as a whole. (200 weeks)

Thumb ----- 32.5%  
 Index finger ----- 21.5  
 Second finger ----- 19.0  
 Third or Ring finger ----- 16.0  
 Fourth or little finger ----- 11.0

Total ----- 100.0%

*of Hand*—below elbow joint—200 weeks.

*of Arm*—above elbow joint—250 weeks.

*of Both Hands*—in same accident—500 weeks.

*of Toes*—(See Below)

Big toe ----- 60 weeks  
 Second toe ----- 30 weeks  
 Third toe ----- 20 weeks  
 Fourth toe ----- 15 weeks  
 Fifth toe ----- 10 weeks

1. The loss of *more than one phalange* of a toe shall be considered as *the loss of the entire toe*.
2. The loss of *not more than one phalange* of a toe shall be considered as the loss of *one-half* ( $\frac{1}{2}$ ) of *the entire toe*.
3. When two or more toes are impaired as the result of the same injury the percent of permanent partial impairment shall be figured on the entire foot. The following percentage table may be used to figure any combination of injury to the foot as a whole. (150 weeks)

Big toe ----- 44.5%  
 Second toe ----- 22.0  
 Third toe ----- 15.0  
 Fourth toe ----- 11.0  
 Fifth toe ----- 7.5

Total ----- 100.0%

*of Foot*—below knee joint—150 weeks.

*of Leg*—above knee joint—200 weeks.

*of Both Feet*—in same accident—500 weeks.

*of Eye*

1. For any permanent reduction of the sight of an eye less than a total loss as specified in paragraph (3) of Section 31 (a), a compensation shall be paid for a period proportionate to the degree of such permanent reduction.

\* Prepared by the Committee on Industrial Health as an amendment to the data contained in “Determination of Disability and Impairment” in the July 1950 Year Book.



2. Permanent loss of the sight of an eye or its reduction to one-tenth (1/10) of normal vision with glasses—150 weeks.

of Both Eyes—permanent loss of sight in the same accident—500 weeks.

of Ear

1. For any permanent reduction of the hearing of one or both ears, less than the total loss as specified in paragraph 4 of Section 31 (a), compensation shall be paid for a period proportionate to the degree of such permanent reduction.
2. Permanent and complete loss of hearing—75 weeks.

of Both Ears—permanent and complete loss of hearing—200 weeks.

Section 31 (b) (1) *Loss of Use:*

The total permanent loss of the use of an arm, hand, thumb, finger, leg, foot, toe or phalange shall be considered as the equivalent of the loss by separation of the arm, hand, thumb, finger, leg, foot, toe or phalange, and compensation shall be paid for the same period as for the loss thereof by separation.

Section 31 (b) (2) *Partial Loss of Use:*

For the permanent partial loss of the use of

an arm, hand, thumb, finger, leg, foot, toe or phalange, compensation shall be paid for the proportionate loss of the use of such arm, hand, thumb, finger, leg, foot, toe or phalange.

Section 31 (b) (3) *Total Permanent Disability:*

For injuries resulting in total permanent disability—500 weeks. (Compensation in any one case is limited to ten thousand dollars (\$10,000).)

Section 31 (b) (6) All other cases of *Permanent Partial Impairment:*

In all other cases of permanent partial impairment, compensation proportionate to the degree of such permanent partial impairment, in the discretion of the Industrial Board, not exceeding five hundred weeks.

Section 31 (b) (7) *Disfigurement:*

In all cases of permanent disfigurement, which may impair the future usefulness or opportunities of the employe, compensation, in the discretion of the Industrial Board, not exceeding two hundred weeks, except that no compensation shall be payable under this paragraph where compensation is payable elsewhere in Section 31.

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Institutions Operated by the State of Indiana.....	38 Jan. 1947; 47, Jan. 1948; 627, July 1949; 575, July 1950; 582, July 1951; 619, July 1952	Taxes on Your Estate Plans, the Effect of Township Trustees Relationships, Medical Care .....	572, July 1950
Interns, Externs and Residents, the Law Pertaining to .....	12, Jan. 1947	Trusts, Life Insurance and Annuities.....	16, Jan. 1947
Investments and Protection .....	40, Jan. 1948	Veterans Administration, Home Town Medical Care Program.....	35, Jan. 1948
License to Practice the Healing Art, New Law Requires Annual Registration of.....	151, Jan. 1948	Veterans Administration, Medical and Hospital Care under the.....	23, Jan. 1947
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Malpractice .....	621, July 1949	Welfare Acts, The Physician and the.....	14, Jan. 1947
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Malpractice, Casualty and Fire Insurance .....	31, Jan. 1948	Workmen's Compensation Act.....	15, Jan. 1947
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Malpractice and Malpractice Suits.....	42, Jan. 1948		
Marriage Laws .....	614, July 1949		





# PRINCIPLES OF MEDICAL ETHICS OF THE AMERICAN MEDICAL ASSOCIATION†

These principles are not laws to govern but are principles to guide to correct conduct." (James Percival's *Principles of Ethics* 1803.)

## CHAPTER I

### GENERAL PRINCIPLES CHARACTER OF THE PHYSICIAN

SECTION 1.—The prime object of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. Whoever chooses this profession assumes the obligation to conduct himself in accord with its ideals. A physician should be "an upright man, instructed in the art of healing." He must keep himself pure in character and be diligent and conscientious in caring for the sick. As was said by Hippocrates, "He should also be modest, sober, patient, prompt to do his whole duty without anxiety; pious without going so far as superstition, conducting himself with propriety in his profession and in all the actions of his life."

### THE PHYSICIAN'S RESPONSIBILITY

SEC. 2.—"The profession of medicine, having for its end the common good of mankind, knows nothing of national enmities, of political strife, of sectarian dissensions. Disease and pain the sole conditions of its ministry, it is disquieted by no misgivings concerning the justice and honesty of its client's cause; but dispenses its peculiar benefits, without stint or scruple, to men of every country, and party and rank, and religion, and to men of no religion at all."\*

### GROUPS AND CLINICS

SEC. 3.—The ethical principles actuating and governing a group or clinic are exactly the same as those applicable to the individual. As a group or clinic is composed of individual physicians, each of whom, whether employer, employee or partner, is subject to the principles of ethics herein elaborated, the uniting into a business or professional organization does not relieve them either individually or as a group from the obligation they assume when entering the profession.

### ADVERTISING

SEC. 4.—Solicitation of patients, directly or indirectly, by a physician, by groups of physicians or by institutions or organizations is unethical. This principle protects the public from the advertiser and salesman of medical care by establishing an easily discernible and generally recognized distinction between him and the ethical physician. Among unethical practices are included the not always obvious devices of furnishing or inspiring newspaper or magazine comments concerning cases in which the physician or group or institution has been, or is, concerned. Self laudations defy the traditions and lower the moral standard of the medical profession; they are an infraction of good taste and are disapproved.

### EDUCATIONAL INFORMATION NOT ADVERTISING

SEC. 5.—Many people, literate and well educated, do not possess a special knowledge of medicine. Medical books and journals are not easily accessible or readily understandable.

The medical profession considers it ethical for a physician to meet the request of a component or constituent medical society to write, act or speak for general readers or audiences. The adaptability of medical material for presentation to the public may be perceived first by publishers, motion picture producers or radio officials. These may offer to the physician opportunity to release to the public some article, exhibit or drawing. Refusal

to release the material may be considered a refusal to perform a public service, yet compliance may bring the charge of self seeking or solicitation. In such circumstances the physician should be guided by the decision of official agencies established through component and constituent medical organizations.

A physician who desires to know whether, ethically, he may engage in a project aimed at health education of the public should request the approval of the designated officer or committee of his county medical society.

The most worthy and effective advertisement possible, even for a young physician, especially among his brother physicians, is the establishment of a well merited reputation for professional ability and fidelity. This cannot be forced, but must be the outcome of character and conduct. The publication or circulation of simple professional cards is approved in some localities but is disapproved in others. Disregard of local customs and offenses against recognized ideals are unethical.

The promise of radical cures or boasting of cures or of extraordinary skill or success is unethical.

An institution may use means, approved by the medical profession in its own locality, to inform the public of its address and the special class, if any, of patients accommodated.

### PATENTS, COMMISSIONS, REBATES AND SECRET REMEDIES

SEC. 6.—An ethical physician will not receive remuneration from patents on or the sale of surgical instruments, appliances and medicines, nor profit from a copyright on methods or procedures. The receipt of remuneration from patents or copyrights tempts the owners thereof to retard or inhibit research or to restrict the benefits derivable therefrom to patients, the public or the medical profession. The acceptance of rebates on prescriptions or appliances, or of commissions from attendants who aid in the care of patients is unethical. An ethical physician does not engage in barter or trade in the appliances, devices or remedies prescribed for patients, but limits the sources of his professional income to professional services rendered the patient. He should receive his remuneration for professional services rendered only in the amount of his fee specifically announced to his patient at the time the service is rendered or in the form of a subsequent statement, and he should not accept additional compensation secretly or openly, directly or indirectly, from any other source.

The prescription or dispensing by a physician of secret medicines or other secret remedial agents, of which he does not know the composition, or the manufacture or promotion of their use is unethical.

### EVASION OF LEGAL RESTRICTIONS

SEC. 7.—An ethical physician will observe the laws regulating the practice of medicine and will not assist others to evade such laws.

## CHAPTER II

### DUTIES OF PHYSICIANS TO THEIR PATIENTS STANDARDS, USEFULNESS, NONSECTARIANISM

SECTION 1.—In order that a physician may best serve his patients, he is expected to exalt the standards of his profession and to extend its sphere of usefulness. To the same end, he should not base his practice on an exclusive dogma or a sectarian system, for "sects are implacable despots; to accept their thralldom is to take away all liberty from one's action and thought."\* A sectarian or cultist as applied to medicine is one who alleges to follow or in his practice follows a dogma, tenet or principle based on the authority of its promulgator to the exclusion of demonstration and scientific experience. All voluntarily associated activities with cultists are unethical. A consultation with a cultist is

† Adopted by the American Medical Association House of Delegates on June 6, 1949.

\* Sir Thomas Watson.

\* Nicon, father of Galen.

a futile gesture if the cultist is assumed to have the same high grade of knowledge, training and experience as is possessed by the doctor of medicine. Such consultation lowers the honor and dignity of the profession in the same degree in which it elevates the honor and dignity of those who are irregular in training and practice.

#### PATIENCE, DELICACY AND SECRECY

SEC. 2.—Patience and delicacy should characterize the physician. Confidences concerning individual or domestic life entrusted by patients to a physician and defects in the disposition or character of patients observed during medical attendance should never be revealed unless their revelation is required by the laws of the state. Sometimes, however, a physician must determine whether his duty to society requires him to employ knowledge, obtained through confidences entrusted to him as a physician, to protect a healthy person against a communicable disease to which he is about to be exposed. In such instance, the physician should act as he would desire another to act toward one of his own family in like circumstances. Before he determines his course, the physician should know the civil law of his commonwealth concerning privileged communications.

#### PROGNOSIS

SEC. 3.—The physician should neither exaggerate nor minimize the gravity of a patient's condition. He should assure himself that the patient, his relatives or his responsible friends have such knowledge of the patient's condition as will serve the best interests of the patient and the family.

#### THE PATIENT MUST NOT BE NEGLECTED

SEC. 4.—A physician is free to choose whom he will serve. He should, however, respond to any request for his assistance in an emergency or whenever temperate public opinion expects the service. Once having undertaken a case, the physician should not neglect the patient, nor should he withdraw from the case without giving notice to the patient, his relatives or his responsible friends sufficiently long in advance of his withdrawal to allow them to secure another medical attendant.

### CHAPTER III

#### DUTIES OF PHYSICIANS TO EACH OTHER AND TO THE PROFESSION AT LARGE

##### ARTICLE I.—DUTIES TO THE PROFESSION UPHOLDING THE HONOR OF THE PROFESSION

SECTION 1.—A physician is expected to uphold the dignity and honor of his vocation.

##### MEMBERSHIP IN MEDICAL SOCIETIES

SEC. 2.—For the advancement of his profession, a physician should affiliate with medical societies and contribute of his time, energy and means so that these societies may represent the ideals of the profession.

##### SAFEGUARDING THE PROFESSION

SEC. 3.—Every physician should aid in safeguarding the profession against admission to it of those who are deficient in moral character or education.

SEC. 4.—A physician should expose, without fear or favor, incompetent or corrupt, dishonest or unethical conduct on the part of members of the profession. Questions of such conduct should be considered, first, before proper medical tribunals in executive sessions or by special or duly appointed committees on ethical relations, provided such a course is possible and provided, also, that the law is not hampered thereby. If doubt should arise as to the legality of the physician's conduct, the situation under investigation may be placed before officers of the law, and the physician-investigators may take the necessary steps to enlist the interest of the proper authority.

#### ARTICLE II.—PROFESSIONAL SERVICES OF PHYSICIANS TO EACH OTHER

##### DEPENDENCE OF PHYSICIANS ON EACH OTHER

SECTION 1.—As a general rule, a physician should not attempt to treat members of his family or himself.

Consequently, a physician should cheerfully and without recompense give his professional services to physicians or their dependents if they are in his vicinity.

##### COMPENSATION FOR EXPENSES

SEC. 2.—When a physician from a distance is called to advise another physician about his own illness or about that of one of his family dependents, and the physician to whom the service is rendered is in easy financial circumstances, a compensation that will at least meet the traveling expenses of the visiting physician should be proffered him. When such a service requires an absence from the accustomed field of professional work of the visitor that might reasonably be expected to entail a pecuniary loss, such loss may, in part at least, be provided for in the compensation offered.

##### ONE PHYSICIAN IN CHARGE

SEC. 3.—When a physician or a member of his dependent family is seriously ill, he or his family should select one physician to take charge of the case. The family may ask the physician in charge to call in other physicians to act as consultants.

#### ARTICLE III.—DUTIES OF PHYSICIANS IN CONSULTATIONS CONSULTATIONS SHOULD BE ENCOURAGED

SECTION 1.—In a case of serious illness, especially in doubtful or difficult conditions, the physician should request consultations.

##### CONSULTATION FOR PATIENT'S BENEFIT

SEC. 2.—In every consultation, the benefit to the patient is of first importance. All physicians interested in the case should be candid with the patient, a member of his family or a responsible friend.

##### PUNCTUALITY

SEC. 3.—All physicians concerned in consultations should be punctual. When, however, one or more of the consultants are unavoidably delayed, the one who arrives first should wait for the others for a reasonable time, after which the consultation should be considered postponed. When the consultant has come from a distance, or when for any other reason it will be difficult to meet the physician in charge at another time, or if the case is urgent, or if it be the desire of the patient, his family or his responsible friends, the consultant may examine the patient and mail his written opinion, or see that it is delivered under seal to the physician in charge. Under these conditions, the consultant's conduct must be especially tactful; he must remember that he is framing an opinion without the aid of the physician who has observed the course of the disease.

##### PATIENT REFERRED TO CONSULTANT

SEC. 4.—When a patient is sent to a consultant and the physician in charge of the case cannot accompany the patient, the physician in charge should provide the consultant with a history of the case, together with the physician's opinion and outline of the treatment, or so much of this as may be of service to the consultant. As soon as possible after the consultant has seen the patient he should address the physician in charge and advise him of the results of the consultant's investigation. The opinions of both the physician in charge and the consultant are confidential and must be so regarded by each.

##### DISCUSSIONS IN CONSULTATION

SEC. 5.—After the physicians called in consultation have completed their investigations, they and the physician in charge should meet by themselves to discuss the course to be followed. Statements should not be made, nor should discussion take place in the presence of the patient, his family or his friends, unless all physicians concerned are present or unless all of them have consented to another arrangement.

##### RESPONSIBILITY OF ATTENDING PHYSICIAN

SEC. 6.—The physician in charge of the case is responsible for treatment of the patient. Consequently, he may prescribe for the patient at any time and is



privileged to vary the treatment outlined and agreed on at a consultation whenever, in his opinion, such a change is warranted. However, after such a change, it is best to call another consultation; then the physician in charge should state his reasons for departing from the course decided at the previous conference. When an emergency occurs during the absence of the physician in charge, a consultant may assume authority until the arrival of the physician in charge, but his authority should not extend further without the consent of the physician in charge.

#### CONFLICT OF OPINION

SEC. 7.—Should the physician in charge and a consultant be unable to agree in their view of a case, another consultant should be called or the differing consultant should withdraw. However, since the patient employed the consultant to obtain his opinion, he should be permitted to state it to the patient, his relative or his responsible friend, in the presence of the physician in charge.

#### CONSULTANT AND ATTENDANT

SEC. 8.—When a physician has acted as consultant in an illness, he should not become the physician in charge in the course of that illness, except with the consent of the physician who was in charge at the time of the consultation.

#### ARTICLE IV.—DUTIES OF PHYSICIANS IN CASES OF INTERFERENCE

##### MISUNDERSTANDINGS TO BE AVOIDED

SECTION 1.—A physician, in his relationship with a patient who is under the care of another physician, should not give hints relative to the nature and treatment of the patient's disorder; nor should a physician do anything to diminish the trust reposed by the patient in his own physician. In embarrassing situations, or whenever there seems to be a possibility of misunderstanding with a colleague, a physician should seek a personal interview with his fellow.

##### SOCIAL CALLS ON PATIENT OF ANOTHER PHYSICIAN

SEC. 2.—When a physician makes social calls on another physician's patient he should avoid conversation about the patient's illness.

##### SERVICES TO PATIENT OF ANOTHER PHYSICIAN

SEC. 3.—A physician should not take charge of, or prescribe for another physician's patient during any given illness (except in an emergency) until the other physician has relinquished the case or has been formally dismissed.

##### CRITICISM TO BE AVOIDED

SEC. 4.—When a physician does succeed another physician in charge of a case, he should not disparage, by comment or insinuation, the one who preceded him. Such comment or insinuation tends to lower the confidence of the patient in the medical profession and so reacts against the patient, the profession and the critic.

##### EMERGENCY CASES

SEC. 5.—When a physician is called in an emergency because the personal or family physician is not at hand, he should provide only for the patient's immediate need and should withdraw from the case on the arrival of the personal or family physician. However, he should first report to the personal or family physician the condition found and the treatment administered.

##### PRECEDENCE WHEN SEVERAL PHYSICIANS ARE SUMMONED

SEC. 6.—When several physicians have been summoned in a case of sudden illness or of accident, the first to arrive should be considered the physician in charge. However, as soon as is practicable, or on the arrival of the acknowledged personal or family physician, the first physician should withdraw. Should the patient, his family or his responsible friend wish some one other than he who has been in charge of the case, the patient or his representative should advise the personal or family physician of his desire. When, because of sudden illness or

accident, a patient is taken to a hospital without the knowledge of the physician who is known to be the personal or family physician, the patient should be returned to the care of the personal or family physician as soon as is feasible.

#### A COLLEAGUE'S PATIENT

SEC. 7.—When a physician is requested by a colleague to care for a patient during the colleague's temporary absence, or when, because of an emergency, a physician is asked to see a patient of a colleague, the physician should treat the patient in the same manner and with the same delicacy that he would wish used in similar circumstances if the patient were his responsibility. The patient should be returned to the care of the attending physician as soon as possible.

#### SUBSTITUTION IN OBSTETRIC WORK

SEC. 8.—When a physician attends a woman who is in labor because the one who was engaged to attend her is absent, the physician summoned in the emergency should relinquish the patient to the first engaged, on his arrival. The one in attendance is entitled to compensation for the professional services he may have rendered.

#### ARTICLE V.—DISPUTES BETWEEN PHYSICIANS

##### ARBITRATION

SECTION 1.—Whenever there arises between physicians a grave difference of opinion, or of interest, which cannot be promptly adjusted, the dispute should be referred for arbitration, preferably to an official body of a component society.

#### ARTICLE VI.—COMPENSATION

##### LIMITS OF GRATUITOUS SERVICE

SECTION 1.—Poverty of a patient, and the obligation of physicians to attend one another and the dependent members of the families of one another, should command the gratuitous services of a physician. Institutions and organizations for mutual benefit, or for accident, sickness and life insurance, or for analogous purposes, should meet such costs as are covered by the contract under which the service is rendered.

##### CONDITIONS OF MEDICAL PRACTICE

SEC. 2.—A physician should not dispose of his services under conditions that make it impossible to render adequate service to his patients, except under circumstances in which the patients concerned might be deprived of immediately necessary care.

##### CONTRACT PRACTICE

SEC. 3.—Contract practice as applied to medicine means the practice of medicine under an agreement between a physician or a group of physicians, as principals or agents, and a corporation, organization, political subdivision or individual, whereby partial or full medical services are provided for a group or class of individuals on the basis of a fee schedule, or for a salary or for a fixed rate per capita.

Contract practice *per se* is not unethical. Contract practice is unethical if it permits of features or conditions that are declared unethical in these Principles of Medical Ethics or if the contract or any of its provisions causes deterioration of the quality of the medical services rendered.

##### FREE CHOICE OF PHYSICIAN

SEC. 4.—Free choice of physician is defined as that degree of freedom in choosing a physician which can be exercised under usual conditions of employment between patients and physicians. The interjection of a third party who has a valid interest, or who intervenes between the physician and the patient does not *per se* cause a contract to be unethical. A third party has a valid interest when, by law or volition, the third party assumes legal responsibility and provides for the cost of medical care and indemnity for occupational disability.

##### COMMISSIONS

SEC. 5.—When a patient is referred by one physician to another for consultation or for treatment, whether

the physician in charge accompanies the patient or not, the giving or receiving of a commission by whatever term it may be called or under any guise or pretext whatsoever is unethical.

#### PURVEYAL OF MEDICAL SERVICE

SEC. 6.—A physician should not dispose of his professional attainments or services to any hospital, lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit exploitation of the services of the physician for the financial profit of the agency concerned. Such a procedure is beneath the dignity of professional practice and is harmful alike to the profession of medicine and the welfare of the people.

### CHAPTER IV

#### THE DUTIES OF PHYSICIANS TO THE PUBLIC PHYSICIANS AS CITIZENS

SECTION 1.—Physicians, as good citizens, possessed of special training, should advise concerning the health of the community wherein they dwell. They should bear their part in enforcing the laws of the community and in sustaining the institutions that advance the interests of humanity. They should cooperate especially with the proper authorities in the administration of sanitary laws and regulations.

#### PUBLIC HEALTH

SEC. 2.—Physicians, especially those engaged in public health work, should enlighten the public concerning quarantine regulations and measures for the prevention of epidemic and communicable diseases. At all times the physician should notify the constituted public health authorities of every case of communicable disease under his care, in accordance with the laws, rules and regulations of the health authorities. When an epidemic prevails, a physician must continue his labors without regard to the risk to his own health.

#### PHARMACISTS

SEC. 3.—Physicians should recognize and promote the practice of pharmacy as a profession and should recognize the cooperation of the pharmacist in education of the public concerning the practice of ethical and scientific medicine.

#### CONCLUSION

These principles of medical ethics have been and are set down primarily for the good of the public and should be observed in such a manner as shall merit and receive the endorsement of the community. The life of the physician, if he is capable, honest, decent, courteous, vigilant and a follower of the Golden Rule, will be in itself the best exemplification of ethical principles.

## CONSTITUTION AND BY-LAWS OF THE INDIANA STATE MEDICAL ASSOCIATION

### CONSTITUTION

#### ARTICLE I.—NAME OF THE ASSOCIATION

The name and title of this organization shall be the Indiana State Medical Association.

#### ARTICLE II.—PURPOSES OF THE ASSOCIATION

The purposes of this Association shall be to federate and bring into one compact organization the medical profession of the State of Indiana, and to unite with similar societies of other states to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; to protect its members against imposition; and to enlighten and direct public opinion in regard to the great problems of medical care, and public health, so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life.

#### ARTICLE III.—COMPONENT SOCIETIES

Component societies shall consist of those county medical societies which hold charters from this Association.

#### ARTICLE IV.—COMPOSITION OF THE ASSOCIATION

Section 1.—This Association shall consist of Active Members, Associate Members, Senior Members and Honorary Members.

Sec. 2.—*Active Members.*—The active members of this Association shall be the members of the component county medical societies, and no county medical society shall grant membership therein on a basis that does not include membership in the Indiana State Medical Association.

Sec. 3.—*Associate Members.*—Members of the Indiana State Dental Association in good standing are, by virtue of their membership therein, made associate members of the Indiana State Medical Association.

Sec. 4.—*Senior Members.*—Senior members shall be physicians of the State of Indiana who have attained the age of seventy-five years and have held membership in the Indiana State Medical Association for twenty years or more, and who, upon their application, have been certified to the executive secretary as eligible for such membership by the county societies of which they are members.

All members who, previous to the adoption of this amendment to the constitution, were certified as honorary members on the basis of the above qualifications, shall hereafter be classified as senior members.

Sec. 5.—*Honorary Members.*—Honorary members shall consist of teachers, scientists and others who have rendered highly meritorious service to the profession of medicine, and of physicians and surgeons of distinction, upon whom the Association may, through vote of the House of Delegates,



desire to confer such membership as a special honor.

**Sec. 6.—Rights and Privileges of Members.**—Active members and senior members shall have the same rights and privileges except as follows:

a. Senior members shall not be required to pay membership dues in the State Association.

b. If senior members desire to receive THE JOURNAL of the State Association, they shall pay the regular subscription price therefor.

c. Honorary members hereafter elected shall hold such membership as an honor and distinction and shall have the right to attend meetings of the Association. They shall have the privilege of participating in discussions but shall have no right to vote or to hold office. They shall not be required to pay membership dues in the State Association.

#### ARTICLE V.—HOUSE OF DELEGATES

The House of Delegates shall be the legislative and business body of the Association and shall consist of (1) Delegates elected by the component county societies; (2) the Councilors; and (3) the ex-presidents of the Indiana State Medical Association. The following shall be *ex-officio* members: the President, the President-elect, the Executive Secretary, the Treasurer of this Association, and the delegates to the American Medical Association, all without power to vote, except in case of a tie vote, when the President or person presiding shall cast the deciding vote.

#### ARTICLE VI.—COUNCIL

The Council shall consist of (1) the Councilors, and (2) *ex officio* the President, President-elect, and Treasurer. Besides its duties mentioned in the By-Laws, it shall constitute the Board of Trustees of this organization, having full charge and control of all the property of the Association. It shall have full authority and power of the House of Delegates between sessions of the House of Delegates, except that it shall not make changes in the laws governing the Association nor exercise legislative functions, except as stated in the By-Laws, and at all times shall be the finance committee of the Association. Seven Councilors shall constitute a quorum.

#### ARTICLE VII.—SECTIONS AND DISTRICT SOCIETIES

The House of Delegates may provide for a division of the scientific work of the Association into appropriate sections; and for the organization of such Councilor District Societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies. Councilor districts shall be defined by the House of Delegates.

#### ARTICLE VIII.—CONVENTION AND MEETINGS

**Section 1.**—The Association shall hold an Annual Convention during which there shall be held such general and section meetings as the Association through its duly constituted officers and committees may provide for.

**Sec. 2.**—The House of Delegates shall select the place two years in advance for holding the annual convention. The time for the convention shall be fixed by the Council, and the Council shall have the power also to change the place for holding the convention where conditions may create difficulties in holding a successful convention at the place designated by the House of Delegates.

**Sec. 3.**—Special meetings of either the Association or the House of Delegates shall be called by the President on petition of twenty delegates or fifty members.

#### ARTICLE IX.—OFFICERS

**Section 1.**—The officers of this Association shall be a President, a President-elect, an Executive Secretary, a Treasurer, and thirteen Councilors, each of whom shall be a member, except the Executive Secretary, who need not necessarily be either a physician or a member.

**Sec. 2.**—The officers, except the Councilors and the Executive Secretary, whose election has been provided for hereinafter, shall be elected annually. The terms of elected Councilors shall be for three years and approximately one-third of the number shall be elected annually. All of these officers shall serve until their successors are elected and installed. Provided, that if any elected Councilor fails, without reason acceptable to the Council, in any one calendar year to attend a majority of the meetings of the Council, he shall thereby cease to be a Councilor, and the Executive Secretary shall thereupon take action in accordance with Section 4 of this article.

**Sec. 3.**—The officers of this Association with the exception of the Executive Secretary shall be elected by the House of Delegates as the first order of business of the last day of the Annual Convention, and no person shall be elected to any such office who is not in attendance on that Annual Convention and who has not been a member of the Association for the preceding two years.

**Sec. 4.**—The Councilors shall be elected by the respective district societies. If any district fails to meet and elect its Councilor by the time of expiration of the incumbent's term of office, the Executive Secretary of the Association shall cause a special meeting to be called by said district society for the purpose of such election.

**Sec. 5.**—Each Councilor district shall elect an alternate Councilor whose term of office shall be the same as the Councilor, namely three years. The alternate Councilor shall be elected in a year during which there is no Councilor elected.

The duties of the alternate Councilor shall be:

1. To represent the Councilor district in the absence of the regularly elected Councilor.

2. To vote only in the absence of the regularly elected Councilor either in the House of Delegates or in Council meetings where he represents the regularly elected Councilor.

3. The alternate Councilor shall not have the power of discussion if the regularly elected Councilor is present.

Sec. 6.—Any officer may be removed from office after a hearing before the Council, on thirty days' notice, on charges in writing, upon a vote of three-fourths of the members of the Council.

Sec. 7.—In event of the death, resignation, removal, or disability of the President, the President-elect shall succeed to the presidency. In the event of the death, disability, resignation or removal of both the President and the President-elect, the chairman of the Council shall become President pro tem and as such shall, within a period of sixty days, call a special session of the members of the House of Delegates for the purpose of electing members to fill these vacancies, who shall serve until the next regular meeting of the House of Delegates, at which time both a President and a President-elect shall be elected, both of whom shall take office immediately upon their election.

Sec. 8.—A vacancy in the office of Treasurer shall be filled by an election by the Councilors at the next regular meeting of the Council following the occurrence of such vacancy.

Sec. 9.—None of the officers shall receive compensation except the Executive Secretary, who shall be employed by the Council, and the Council shall fill any vacancy in that office.

#### **ARTICLE X.—RECIPROCITY OF MEMBERSHIP WITH OTHER STATE SOCIETIES**

In order to broaden professional fellowship, this Association is ready to arrange with other State Medical Associations for an interchange of certificates of membership so that members moving from one state to another may avoid the formality of re-election.

#### **ARTICLE XI.—INCOME AND EXPENSES**

Funds for carrying on the activities of this Association shall be raised by the following means:

a. Membership dues to be collected by the component county societies in connection with the dues for such component societies. The amount of the dues of each component society shall be fixed by the society itself; and the amount of dues for this Association shall be fixed from time to time by the House of Delegates.

b. Voluntary contributions.

c. Revenues derived from the Association's publications.

d. Any other manner approved by the House of Delegates.

Funds may be appropriated by the House of

Delegates to defray the expenses of the Association, for publications, and for such other purposes as will promote the welfare of the profession. All motions and resolutions appropriating funds must be referred to the Council for approval before final action is taken thereon.

#### **ARTICLE XII.—REFERENDUM**

Section 1.—A General Meeting of the Association may, by a two-thirds vote of the members present, order a general referendum on any question pending before the House of Delegates, and when so ordered the House of Delegates shall submit such question to the members of the Association, who may vote by mail or in person, and if the members voting shall comprise a majority of all the members of the Association, a majority of such vote shall determine the question and be binding on the House of Delegates.

Sec. 2.—The House of Delegates may, by a two-thirds vote of its own members, submit any question before it to a general referendum, as provided in the preceding section, and the result shall be binding on the House of Delegates.

#### **ARTICLE XIII.—THE SEAL**

The Association shall have a common Seal, with power to break, change or renew the same at pleasure.

#### **ARTICLE XIV.—AMENDMENTS**

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates present at any Annual Convention, provided that such amendment shall have been presented in open meeting at the previous Annual Convention, and that it shall have been published twice during the year in THE JOURNAL of this Association.

#### **BY-LAWS**

##### **CHAPTER I.—MEMBERSHIP**

Section 1.—The term "Member" as used in these By-Laws unless otherwise indicated shall mean both active and senior members. Provided, however, that he is a citizen of the United States of America, or has filed his declaration of intention of becoming a citizen and his first citizenship papers are in full force and effect.

Sec. 2.—Any physician who is a member in good standing of a component county society and who has paid to this Association his annual dues is a member in good standing of the Indiana State Medical Association, provided, however, that he is a citizen of the United States of America, or has filed his declaration of intention of becoming a citizen and his first citizenship papers are in full force and effect.

Sec. 3.—No person who is under sentence of suspension or expulsion from a component society, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Association, nor shall he be permitted to take part in any of its proceedings until he has been relieved of such disability.



Sec. 4.—Each member in attendance at the Annual Convention shall register by indicating the component society of which he is a member. When his right to membership has been verified, by reference to the roster of his society, he shall receive a badge, which shall be evidence of his right to all the privileges of membership at that convention. No member shall take part in any of the proceedings of an Annual Convention until he has complied with the provisions of this section.

#### CHAPTER II.—GENERAL MEETINGS

Section 1.—General Meetings shall mean all meetings planned for attendance by all registered members, and shall include those meetings in which guests of registered members or the general public are also invited. The address of the President shall be delivered in a General Meeting, and the programs of General Meetings shall be arranged by the Executive Committee except where scientific papers are included, in which event the scientific part of the program shall be arranged by the Committee on Scientific Work, with the sanction and approval of the officers.

Sec. 2.—The General or Section Meetings may recommend to the House of Delegates the appointment of committees or commissions for scientific investigation of special interest and importance to the profession and public.

Sec. 3.—All scientific papers read before the Association or any of the sections shall become its property and shall not be published in any but the official publications of this Association, except by consent of the officers and the Editorial Board of this Association. Each such paper shall be deposited with the Executive Secretary when read.

Sec. 4.—The Council shall appropriate from the funds of the Association for each Annual Convention, for the entertainment of its members and guests, such an amount as in the discretion of the Council shall be reasonably needed for that purpose, and no commitments shall be made for expenses in excess of the amount appropriated for such convention. The entertainment funds so appropriated shall be expended at the direction of the Committee on Convention Arrangements, appointed by the President for the convention for which the appropriation is made. All money in excess of that expended for actual expenses incurred shall revert each year to the treasury of the State Association.

#### CHAPTER III.—SECTIONS

Section 1.—During the Annual Convention the Association in addition to the general meetings may hold the following section meetings:

- a. Surgical.
- b. Medical.
- c. Eye, Ear, Nose, and Throat.
- d. Anesthesia.
- e. General Practice.
- f. Obstetrics and Gynecology.

g. Preventive Medicine and Public Health.

h. Any other sections that hereafter may be provided for by the House of Delegates.

Sec. 2.—The officers of each section shall be a Chairman, a Vice-Chairman, and a Secretary, and they shall preside over the meetings of the sections and shall be responsible to the Committee on Scientific Work for the section speakers and papers.

Sec. 3.—The election of officers of the sections shall be the last order of business of the last meeting of the sections during the Annual Convention.

Sec. 4.—No section meeting shall be allowed to conflict with a general meeting.

#### CHAPTER IV.—HOUSE OF DELEGATES

Section 1.—The House of Delegates shall meet the day before or during that fixed as the first day of the scientific meeting of the Annual Convention. It may adjourn from time to time as may be necessary to complete its business, provided that its hours shall conflict as little as possible with the General or Section Meetings. It shall meet on the last day of the Annual Convention for the election of officers for the ensuing year, and for the completion of any business previously introduced. The order of business shall be arranged as a separate section of the program.

Sec. 2.—Each component county society shall be entitled to send to the House of Delegates each year one delegate for every fifty members and one for each major fraction thereof; but, irrespective of the number of members, each component society which has made its annual report and paid its assessments, as provided in this Constitution and By-Laws, shall be entitled to one delegate, except that where a component society is made up of physicians of more than one county, each county shall be entitled to at least one delegate to be selected by the physicians residing in such county.

The names of duly elected delegates and alternates from each component society shall be sent to the Executive Secretary of this Association annually on or before August first prior to the Annual Convention at which such delegates are to serve. No one shall be entitled to a seat in the House of Delegates unless his credentials as a delegate or alternate, properly signed by the secretary of his county society, be presented to the Committee on Credentials at the time of the Annual Convention.

Sec. 3.—Fifty delegates shall constitute a quorum.

Sec. 4.—The House of Delegates shall:

a. Elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and By-Laws of that body.

b. Divide the State into Councilor Districts, specifying what counties each district shall include, and when the best interests of the Asso-

ciation and profession will be promoted thereby, organize in each district a medical society, and all members of component county societies, and no others, shall be members of such district societies.

c. Have authority to appoint committees for special purposes from among members of the Association who need not be members of the House of Delegates. Such committees shall report to the House of Delegates, and the members of such committees may be present and participate in the debate on their reports.

d. Approve all memorials and resolutions issued in the name of the Association before the same shall become effective.

Sec. 5. — Funds may be appropriated by the House of Delegates, subject to approval by the Council, for such purposes as will promote the welfare of the Association and the profession.

Sec. 6.—At the first meeting the President shall announce the membership of the reference committees, as hereinafter provided for, and any other committees considered by him necessary to expedite the business of the Association.

Sec. 7.—In addition to the meetings provided for in Section 1 of this Chapter IV, a meeting of the House of Delegates shall be held each year as nearly as is conveniently possible, six months after the last meeting provided for in said Section 1. The date and place of this meeting shall be fixed by the Council in its regular January meeting of each year, and notice thereof shall be published in the next JOURNAL of the association. Not less than thirty days before such meeting, written notices shall be sent to all Delegates, in which notices shall be included the agenda for the meeting, on which agenda shall be a statement of each item to come before the meeting so far as is known to the Executive Secretary at the time the said notices are prepared for mailing. After the business listed on the agenda has been disposed of in the meeting, new business presented in the form of resolutions or motions from the floor will be considered and disposed of.

#### CHAPTER V.—ELECTION OF OFFICERS

Section 1.—The election of officers shall be the first order of business of the House of Delegates after the reading of the minutes on the last day of the Annual Convention.

Sec. 2.—All elections shall be by ballot, and a majority of the votes cast shall be necessary to elect. In case no nominee receives a majority on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken.

Sec. 3.—Any person known to have solicited votes for or sought any office within the gift of this Association shall be ineligible for any office for two years.

Sec. 4.—The President, President-elect, and the Treasurer shall serve from the termination of the annual meeting of the House of Delegates in which the President-elect and Treasurer are elected

until the termination of the succeeding annual meeting of the House of Delegates.

#### CHAPTER VI.—DUTIES OF OFFICERS

Section 1.—The President, or a member designated by him, shall preside at all general meetings of the Association and of the House of Delegates. The President shall appoint all committees not otherwise provided for; he shall deliver an annual address at such time as may be arranged by the Executive Committee, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the state during his term of office, and as far as practicable, shall visit by appointment the various sections of the state and assist the Councilors in building up the county societies and in making their work more practical and useful.

Sec. 2.—The President-elect's term of office shall be for one year, at the completion of which he succeeds to the presidency. While President-elect, he shall assist the President in the discharge of his duties.

Sec. 3.—The Treasurer shall give bond at the expense of the Association in such an amount as shall be required by the Council. He shall receive all bequests and donations to the Association and shall demand and receive all funds due the Association except accounts due THE JOURNAL in the conduct of its business. The funds of the Association shall be deposited in a depository or depositories designated by the Executive Committee, and withdrawals from such funds shall be made on checks or drafts signed by the Treasurer and the Chairman of the Council. He shall present to the House of Delegates annually a report of the receipts and expenditures, and the state of the funds in his hands, and shall subject his accounts to an annual audit by a Certified Public Accountant.

Sec. 4.—The Executive Secretary shall be the directing manager of the Association's headquarters and Journal offices, and shall supervise the work of all salaried employees in the Association offices. Such supervision shall be subject to directives from the House of Delegates, the Council, the Executive Committee, and the President of the Association. He shall discharge the administrative functions of the Association not within the duties of other officers or of committees to perform. He shall assist, at their request, all officers and committees, and shall keep himself informed in regard to non-professional matters affecting the medical profession, for the purpose of keeping himself qualified to perform the services herein mentioned. He shall be responsible for the execution and carrying out of the policies of the Association and in that connection shall perform all specific tasks committed to him by the committees, the Council, and the officers of this Association. The amount of his salary shall be fixed by the Executive Committee on approval of the Council.



Sec. 5.—The necessary expenses of the above officers incurred in the line of duty herein imposed may be allowed by the Council, but excepting the Executive Secretary, this shall not include the expense of attending the Annual Convention.

#### CHAPTER VII.—COUNCIL

Section. 1.—The Council shall meet as follows: 1. January, April, and July of each year on dates and at places fixed by the Council. 2. On the day preceding the first day for the scientific meetings of the Annual Convention of the Association. 3. On the last day of the Annual Convention of the Association after the adjournment of the House of Delegates. 4. At such other times as necessity may require, subject to the call of the Chairman, or on petition of three Councilors. It shall hold no meeting that will conflict with any meeting of the House of Delegates. It shall elect a Chairman, and a Clerk, who, in the absence of the Executive Secretary of the Association, shall keep a record of its proceedings. It shall, through its Chairman, make an annual report to the House of Delegates.

Sec. 2. — Each Councilor shall be organizer, peacemaker, and censor for his district. He shall visit the counties in his district at least once a year for the purpose of organizing component societies where none exist; for inquiring into the condition of the profession, and for improving and increasing the zeal of the county societies and their members. He shall make an annual report of his work and of the condition of the profession of each county in his district, the same to be published in the number of *THE JOURNAL* which is issued immediately preceding the Annual Convention. The House of Delegates may take such action, if any, as it deems appropriate upon such reports. The necessary expenses incurred by such Councilor in the line of the duties herein imposed may be allowed by the Council on a properly itemized statement, but this shall not be construed to include his expense in attending the Annual Convention of the Association.

Sec. 3.—The Council shall, through its officers and otherwise, give diligent attention to and foster the scientific work and spirit of the Association, and shall study and strive constantly to make each Annual Convention a stepping stone to future ones of higher interest.

Sec. 4.—The Council shall, in connection with the House of Delegates, consider and advise as to the interests of the profession and of the public in those important matters wherein it is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation and to diffuse popular information in relation thereto.

Sec. 5.—The Council shall make careful inquiry into the condition of the profession of each county in the state and shall have authority to adopt such methods as may be deemed most efficient for build-

ing up and increasing the interest in such county societies as already exist, and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse among physicians of the same locality and shall continue these efforts until every physician in every county of the state who can be made reputable has been brought under medical society influence.

Sec. 6.—The Council shall encourage postgraduate and research work, as well as home study, and shall endeavor to have the results utilized and intelligently discussed in the county societies.

Sec. 7.—The Council shall, upon application, provide and issue charters to county societies organized to conform to the spirit of this Constitution and By-Laws.

Sec. 8.—In sparsely settled sections it shall have authority to organize the physicians of two or more counties into societies to be designated by hyphenating the names of two or more counties so as to distinguish them from district and other classes of societies; and these societies, when organized and chartered, shall be entitled to all the privileges and representation provided herein for county societies, until such counties may be organized separately.

Sec. 9.—The Council shall be the Board of Censors of the Association. It shall consider all questions involving the rights and standings of members whether in relation to other members, to the component societies, or to this Association. All questions of an ethical nature brought before the House of Delegates or the General or Section Meetings shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members of component societies on which an appeal is taken from the decision of an individual Councilor, and its decision in all such matters shall be final.

Sec. 10.—The Council shall provide for and superintend all publications of the Association, and shall have authority to appoint an editor and such assistants as it deems necessary, and fix the amounts of their salaries. The proceedings of the Council for the year shall be reported to the House of Delegates at the Annual Convention and be published in the number of *THE JOURNAL* which immediately precedes the Annual Convention.

Sec. 11.—In the interim between the meetings of this Association the Council shall be the executive body of the Association with full power to fill vacancies or transact any business that emergencies or the welfare of the Association may require.

Sec. 12.—The Council shall elect two members of the Association, who, with the President, the President-elect, the Treasurer, and the Chairman of the Council, shall constitute and be known as the Executive Committee.

## CHAPTER VIII.—STANDING COMMITTEES

Section 1.—The standing committees shall be as follows:

The Executive Committee.

Board of Appeals on Physician Relations.

A Committee on Convention Arrangements.

A Committee on Conference of County Medical Society Officers.

A Committee on Scientific Work.

A Committee on Scientific Exhibits.

A Committee on Public Policy and Legislation.

A Committee on Publicity.

A Committee on Industrial Health.

A Committee on Medical Education and Hospitals.

A Committee on Public Relations.

A Committee on Constitution and By-Laws.

A Committee on Rural Health.

Such committees, except the Executive Committee, which is elected by the Council, shall be appointed by the President of the Association.

All members of committees shall serve for one year unless otherwise specified in these By-Laws or in the authorization for appointment.

Sec. 2.—*The Executive Committee*, consisting of six members as heretofore provided for, shall meet on the call of the Chairman or of any three members with the Executive Secretary to plan and execute such work as may be necessary for the welfare of the Association and the conduct of the Executive Secretary's office. It shall constitute the Medical Defense Committee of the Association and shall have full authority governing all matters pertaining to the medical defense features of this Association, and shall be governed by the rules and regulations concerning such features as provided for in the By-Laws of this Association. It shall represent the Council during the intervals between meetings of that body, including matters pertaining to THE JOURNAL of the Association, and shall report its doings to the Council.

It shall prepare a budget for the ensuing calendar year; and all expenditures of the Association, except those otherwise provided for under the Constitution and By-Laws, shall be governed by the budget. No expense not provided for in the budget or otherwise under the Constitution and By-Laws shall be incurred by any officer or committee. A committee or an officer may submit a request for funds to meet unusual expenses not included in the annual budget, and the Executive Committee shall have the power, by a two-thirds vote, to amend the budget to provide such funds.

Sec. 3.—*The Committee on Convention Arrangements* shall consist of five or more members. With the advice and assistance of the Executive Secretary this committee shall provide suitable accommodations for the meetings of the Association, including the House of Delegates, Council, and of their respective committees, the scientific and technical exhibits, and in conjunction with the Executive Secretary shall have general charge of all the arrangements. Its chairman shall report

an outline of the arrangements to the Executive Secretary of the Association for publication in THE JOURNAL and in the official program, and shall make additional announcements during the session as occasion may require. The arrangements for and the character of any and all technical exhibits must meet with the approval of the Executive Committee of the Association.

Sec. 4.—*The Committee on Scientific Work* shall consist of three or more appointive members appointed by the President; and of the chairman of the Committee on Scientific Exhibits and of the chairmen of the sections as *ex officio* members. It shall be the duty of the officers of the various sections to prepare and submit to this committee prior to the first meeting of the committee a suggested program of subjects and personnel for their respective section programs for the Annual Convention. The scientific program and the financial requirements to provide for it must be approved by the Executive Committee before the program is officially announced.

Sec. 5.—*The Committee on Scientific Exhibits* shall consist of five or more appointive members. It shall have the duty of arranging for scientific exhibits as a part of the Annual Convention, subject to the approval of the Executive Committee.

Sec. 6.—*The Committee on Public Policy and Legislation* shall consist of at least five or more appointive members. Under direction of the House of Delegates it shall represent the Association in securing and enforcing legislation in the interest of public health, medical education, scientific medicine, and the improvement of the medical profession. It shall keep in touch with professional and public opinion and shall endeavor to create and direct public opinion to the end that the public will demand adequate legislation for the promotion of the public good in relation to medicine and the enforcement of such legislation.

Sec. 7.—*The Committee on Publicity* shall consist of three appointive members. It shall be responsible for the dissemination of information concerning individual and community health to the lay public through articles prepared for publication in lay publications, and for addresses or talks delivered before lay audiences under the authority of the Association, and shall in every way seek to give the lay public a better knowledge and understanding of the aims and objects of scientific medicine.

Sec. 8.—*The Committee on Industrial Health* shall consist of five or more appointive members. The duties of the committee shall be: To study and gather facts and become intimately acquainted with the problems regarding industrial health, including any such problems as those relating to the prevention and cure of industrial injuries and diseases; to study the method and means of providing adequate medical and hospital care for those suffering from industrial diseases and injuries; and to encourage cooperation and mutual



understanding among the members of the medical profession, employers of labor, employees and insurance carriers.

Sec. 9.—*The Committee on Medical Education and Hospitals* shall consist of five appointive members. The duties of this committee shall be to cooperate with the authorities of the Indiana University School of Medicine in efforts to improve the educational standards of the state as they pertain to the practice of medicine; to act in conjunction with the members of the Council in providing postgraduate clinics or teaching for the various Councilor medical districts of the state; to cooperate with the Hospital Council of the Indiana State Board of Health in connection with the making and recommending of rules and regulations for the management of hospitals; to select one of its own members as a delegate to the yearly Conference on Medical Education and Hospitals of the American Medical Association; and to cooperate with the corresponding Council of the American Medical Association.

Sec. 10.—*The Committee on Public Relations* shall consist of five or more appointive members. The duties of the committee shall be to develop and carry on continuously a program to improve and sustain good will among the members of the medical profession and the general public; to study and assemble information regarding the means by which the interests of the public relations of the medical profession may best be served; to obtain through public and professional contacts and report to the profession through proper means information regarding the sentiments, criticism and suggestions for improvement which may be made either by members of the profession or by the lay public; and to have the special responsibility of furnishing leadership and guidance in keeping the medical profession as a whole within the deserved respect and esteem of the people.

Sec. 11.—*The Committee on Constitution and By-Laws* shall consist of five appointive members. The duties of this committee shall be: to keep in contact with the developments and changes in procedures in carrying on the work of this Association; to suggest revisions necessary to keep the Constitution and By-Laws always in accord with the practices and procedures best adapted to the functioning of the Association; and to keep the practices and procedures consistent with the provisions from time to time contained in the Constitution and By-Laws—to the end that all members of the profession, by reference to the Constitution and By-Laws, may be able to obtain accurate information regarding procedure and practices within the Association, and that hampering of such procedure and practice by obsolete provisions in

Sec. 12.—*The Committee on Conference of the Constitution and By-Laws* may be avoided.

*County Medical Society Officers* shall consist of seven appointive members. It shall have the duty of arranging for conferences of County Medical

Society Officers, preparing the agenda therefor, and fixing the time and place for such meetings.

Sec. 13.—A standing committee to be known as "The Board of Appeals on Patient-Physician Relations" shall be composed of nine physicians, three of whom shall be past presidents of the association, and all of whom shall be appointed by the president of the association. Not more than one physician shall be appointed from any one Councilor District. No member shall hold any elective office in the state association during tenure on this committee. Of the nine physicians first appointed, three, including one past president, shall serve for a period of one year; three, including one past president, for two years; three, including one past president, for three years. Thereafter three shall be appointed each year for a three year term, to fill the vacancies caused by the expiration of terms. Any vacancy occurring in this committee other than by expiration of terms shall be filled by an interim appointee to serve the balance of the unexpired term. This committee shall organize itself by electing a chairman, vice-chairman, and secretary.

Sec. 14.—The duties of this Board of Appeals on Patient-Physician Relations shall be to receive complaints, appeals or suggestions from physicians or laymen concerning professional conduct. It shall attempt to find the facts regarding any matter brought to its attention, through procedures proper and appropriate to that end, and shall attempt to adjust differences between patients and physicians. It may, if it believes the facts justify such action, cite the member to the Council of the state association. It shall, subject to the approval of the Council, draw up a set of rules and regulations governing the procedure and official actions of the Board.

Sec. 15.—The President and Executive Secretary shall be *ex officio* members of all the foregoing standing Committees where their inclusion on the committee is not otherwise provided for in these By-Laws.

#### CHAPTER IX.—SPECIAL COMMITTEES

The President may appoint such other committees in addition to the standing committees as he deems necessary or as may be specially authorized by the House of Delegates, the Council, or the Executive Committee. Any such committees shall be known as special committees.

#### CHAPTER X.—REFERENCE COMMITTEES

Section 1.—Immediately after the organization of the House of Delegates at each Annual Convention, the President shall announce the membership of the reference committees to serve during the convention for which they are appointed. Appointments to these reference committees shall be made by the President in time for them to be published in THE JOURNAL and the Handbook prior to such Annual Convention.

The President shall have the power to appoint substitutes from among the members present for absent appointees.

Each committee shall consist of five members, the chairman to be specified by the President. To these committees shall be referred all reports, resolutions, measures and propositions presented to the House of Delegates, except such matters as properly come before the Council, and the recommendations of these committees shall be submitted to the next meeting of the House of Delegates for acceptance in the original or modified form or for rejection.

**Sec. 2.**—The following reference committees are hereby constituted:

(1) A Committee on Sections and Section Work to which shall be referred all matters relating to the sections or section work.

(2) A Committee on Rules and Order of Business to which shall be referred all matters regarding rules governing the action, methods of procedure, and order of business of the House of Delegates.

(3) A Committee on Medical Education and Hospitals to which shall be referred all matters relating to medical education and medical colleges and hospitals.

(4) A Committee on Public Policy and Legislation to which shall be referred all matters relating to state and national legislation, and memorials to the legislature, to the United States Congress, to the Governor of the State, or to the President of the United States.

(5) A Committee on Publicity to which shall be referred all matters relating to publicity.

(6) A Committee on Hygiene and Public Health to which shall be referred all matters relating to hygiene and public health.

(7) A Committee on Amendments to the Constitution and By-Laws to which shall be referred all proposed amendments to the Constitution and By-Laws.

(8) A Committee on Reports of Officers to which shall be referred the address of the President and the reports of the Executive Secretary, Treasurer, and the Council.

(9) A Committee on Credentials to which shall be referred all questions regarding registration and the credentials of delegates.

(10) A Committee on Miscellaneous Business to which shall be referred all business not otherwise disposed of.

**Sec. 3.**—The time and place of meetings of all reference committees shall be publicly posted, and all meetings of all reference committees shall be open to all members of the Association.

Officers and chairmen of all committees whose reports are referred to reference committees shall have the right to appear and be heard before the respective committees to which such references are made, in regard to their reports.

## CHAPTER XI.—COUNTY SOCIETIES

**Section 1.**—All county societies now in affiliation with this Association or those which may hereafter be organized in this state, which have

adopted principles of organization not in conflict with this Constitution and By-Laws, shall, on application, receive a charter from and become a component part of this Association. The acceptance or retention of this charter shall be regarded as a pledge on the part of said component society to conduct itself in harmony with the letter and spirit of this Constitution and By-Laws and other rules and resolutions of this Association.

**Sec. 2.**—Charters shall be issued only upon approval of the Council and shall be signed by the President and Executive Secretary of this Association. The Council shall have authority to revoke the charter of any component society whose actions are in conflict with the letter and spirit of this Constitution and By-Laws.

**Sec. 3.**—Only one component medical society shall be chartered in any county. Where more than one county society exists, friendly overtures and concessions shall be made, with the aid of the Councilor for the district if necessary, and all of the members brought into one organization. In case of failure to unite, an appeal may be made to the Council, which shall decide what action shall be taken.

**Sec. 4.**—Each county society shall be judge of the qualifications of its own members, but, as such societies are the only portals to this Association and to the American Medical Association, every reputable and legally registered physician who does not practice or claim to practice, nor lend his support to, any exclusive system of medicine, shall be entitled to membership. Before a charter is issued to any county society, full and ample notice and opportunity shall be given to every physician in the county to become a member.

**Sec. 5.**—Any physician who may feel aggrieved by the action of the society of his county in refusing him membership, or in suspending or expelling him, shall have the right to appeal to the Council, and its decision shall be final.

**Sec. 6.**—In hearing appeals the Council may admit oral or written evidence as in its judgment will best and most fairly present the facts, but in case of every appeal, both as a board and as individual Councilors in district and county work, efforts at conciliation and compromise shall precede all such hearings.

**Sec. 7.**—When a member in good standing in a component society moves to another county in this state his name, on request, shall be transferred without cost to the roster of the county society into whose jurisdiction he moves, provided the transfer is approved by majority vote of the membership of said society to which the membership is proposed.

**Sec. 8.**—A physician living on or near a county line may hold his membership in that county most convenient for him to attend, on permission of the society in whose jurisdiction he has his office or has the major part of his practice.

**Sec. 9.**—Each component society shall have gen-



eral direction of the affairs of the profession in its county, and its influence shall be constantly exerted for bettering the scientific, moral and professional status of every physician in the county; and systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified and honorable physician in the county.

Sec. 10.—At the annual business meeting for election of other officers, in advance of the Annual Convention of this Association, each county society shall elect delegates and alternates to represent it in the House of Delegates of this Association, and the secretary of the society shall send a list of such delegates and alternates to the Executive Secretary of this Association annually on or before August first.

Sec. 11.—The secretary of each component society shall keep a roster of all its members and of the non-affiliated registered physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary. In keeping such roster the secretary shall note any changes in the personnel of the profession by death, or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

The secretary of each component society shall prepare and send to the Councilor of his district a quarterly report briefly stating the activities of his county society including meetings, programs, changes in officers and personnel of membership. A copy of this quarterly report to the Councilor shall also be sent to the Executive Secretary of the State Association. The State Association shall supply each county secretary a form for these reports.

Sec. 12.—The fiscal year of the Association shall be the calendar year, and all dues shall be for the year and *payable in advance*. The secretary of each component society shall forward the dues for his society, together with the roster of officers and members and list of non-affiliated physicians of the county, to the Executive Secretary of this Association, on or before January 1 of each year and he shall promptly report thereafter the names of any new members elected to membership in his society, and promptly forward to the Executive Secretary of this Association the dues for such new members. The dues shall be the same for all members and entitle the members to all benefits, including the publications of this Association, from the time of paying the dues to the close of the year only. Provided, however, that physicians elected to their first membership in this Association during the first nine months of any year shall pay the regular annual dues for that year; and those elected to their first membership after October 1 of any one year shall pay \$10.00 as dues for the remainder of that

year. Interns and residents shall pay \$10.00 a year annual dues during their term of service in the hospital. In the event the county society remits a member's dues for good cause, and the secretary of the county medical society recommends in writing the remission of the state association dues of said member of the society, and shows good cause why such recommendation should be granted, the Council shall have the power to remit such dues.

Sec. 13.—Any county society which fails to pay its dues or make the report required by February 1 of each year shall be held suspended, and none of its members or delegates shall be permitted to receive any of the publications of the Association or participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met.

Sec. 14.—Each county society shall be held responsible for the faithfulness in the performance of duty on the part of its secretary in making reports and remitting dues to the Association.

Sec. 15.—Each component society shall have its own Constitution and By-Laws, not in conflict with the Constitution and By-Laws either of this Association or of the American Medical Association, a copy of which shall be filed with the Executive Secretary of this Association; and furthermore, the Executive Secretary shall be notified at once of any changes or amendments that may be made from time to time.

## CHAPTER XII.—MISCELLANEOUS

Section 1.—The deliberations of this Association shall be governed by parliamentary usage as contained in Robert's Rules of Order, when not in conflict with this Constitution and By-Laws.

Sec. 2.—The Principles of Medical Ethics of the American Medical Association shall govern the conduct of members in their relations to each other and to the public.

## CHAPTER XIII.—MEDICAL DEFENSE

Section 1.—One dollar and twenty-five cents out of the annual dues of each member of the Association shall be set aside as a special fund for medical defense.

Sec. 2.—The administration of medical defense of this Association shall be intrusted to the Executive Committee, which shall constitute the Medical Defense Committee of the Association.

Sec. 3.—This committee shall have full authority governing all matters pertaining to the medical defense features of this Association; with power to enter into agreement for the payment of fees of one attorney whom the physician sued shall have the right to choose, provided such attorney is of good reputation and standing at the bar, and to employ expert witnesses and incur such other expenses as in the judgment of the committee may be necessary in the defense of members against whom suits may be brought;

provided, always, that the total expenditure in any single suit shall not exceed 25 per cent of the fund available at the time suit is filed; and provided further that this Association shall not be liable for attorney's fees in such suits unless this committee shall have first agreed in each case with the physician sued and the attorneys representing him in regard to the terms of such employment, including the fees to be paid.

Sec. 4.—The Treasurer of the Indiana State Medical Association shall be custodian of the defense fund, separately kept, and shall give such additional bond as may be demanded by the Medical Defense Committee. Payments out of this fund shall be made only upon approval of the Executive Committee, by checks signed by the Treasurer and the Chairman of the Council.

Sec. 5.—The Medical Defense Committee shall make an annual report to the House of Delegates of the cases in which it has been of service to members and furnish an account of the money received and expended, such report to be published in THE JOURNAL of the Indiana State Medical Association at the time and in the manner that reports of other committees of the Association are published.

Sec. 6.—This Association shall not be liable for any damage awarded, but shall be liable only for such expenses for the legal defense of its members as may be incurred in accordance with the terms of these By-Laws.

Sec. 7.—The Association shall not undertake the defense of a member in any case in which the member who applies for medical defense by the Association has failed to pay his annual dues for the year in which services were rendered which are the basis of the suit; and medical defense by the Association shall not be available in any suit based on services rendered during any period of delinquency in the payment of dues. Dues are payable on January 1, and become delinquent on February 1 of each year. The membership card of this Association, duly signed and dated by the Executive Secretary, shall be considered the only *bona fide* evidence of payment of dues or membership in this Association.

The Indiana State Medical Association shall in no case provide medical defense against any action for alleged malpractice against any physician unless such physician was a member of this Association in good standing at the time the services which are the basis of the suit were rendered.

Sec. 8.—A member desiring to avail himself of the services of the Medical Defense Committee in connection with litigation brought or threatened must send to the Executive Secretary of the Association for an application blank. After completing the data concerning the case he shall submit to a local committee of his county medical society—to be composed of the President, Secretary and one other member in good standing who may be nominated by the defendant—a full state-

ment of the question at issue, including the diagnosis and treatment of the case and the names of physicians, nurses and other persons having knowledge of the same, who may be summoned as witnesses.

Sec. 9.—The committee of the county medical society shall immediately, after an investigation of all the circumstances and facts, transmit its report, with recommendations, to the Medical Defense Committee of this Association.

Sec. 10.—In the event that the county committee shall fail to recommend the case as one worthy of the recognition of this Association, a direct appeal may be made to the Medical Defense Committee of this Association, whose decision shall be final.

Sec. 11.—Suits brought against the estate of a deceased member shall be defended as if that member were alive; provided that such member was in good standing in the Association at the time of his death and that services for which indemnity is asked were rendered while the deceased was a member in good standing.

Sec. 12.—Medical defense shall not be available to members living outside of the State of Indiana at the time services were rendered for which indemnity is claimed.

Sec. 13.—The Medical Defense Committee shall have power to adopt such other rules, not in conflict with the foregoing, as in their judgment may seem necessary.

Sec. 14.—Medical defense as provided for by this Association shall be available to members under the terms stated in these By-Laws only in the defense of civil action for alleged malpractice, and shall not be available if such alleged malpractice occurred when the member was under the influence of any intoxicant or narcotic while rendering the service in question.

#### CHAPTER XIV.—DIVISION OF FEES

This Association does not countenance or tolerate fee-splitting, division of fees, or commission paying directly or indirectly, and any member found guilty shall be expelled from membership.

#### CHAPTER XV.—INVESTMENT OF SURPLUS FUNDS

Section 1.—All surplus funds of this association shall hereafter be invested only in United States Government bonds or in municipal bonds which the United States Government or the municipalities issuing such bonds shall have the direct obligation to pay.

#### CHAPTER XVI.—AMENDMENTS

Section 1.—These By-Laws may be amended at any Annual Convention by a majority vote of all the delegates present at that convention, after the amendment has lain on the table for one day.

Sec. 2.—Upon the adoption of this Constitution and By-Laws all previous Constitutions and By-Laws are hereby repealed.



# Membership Roster

## INDIANA STATE MEDICAL ASSOCIATION

Following is a list of members of the Indiana State Medical Association as of December 31, 1951, plus those who have become members between December 31, 1951 and June 1, 1952.

The letter (S) following a name indicates that the physician is a senior member of his local society and of the Indiana State Medical Association. The letter (H) following a name indicates that the physician is an honorary member of his local society and the Indiana State Medical Association.

Names of members who have died during the year do not appear in this list.

If any errors are found in this list, please report them to THE JOURNAL, 1017 Hume Mansur Building, Indianapolis 4, Indiana. The cooperation of members is urgently requested.

### ALPHABETICAL LIST OF MEMBERS

#### A

Name	City	County	Name	City	County
Aagesen, J. W.	Anderson	Madison	Allen, Orris T.	Terre Haute	Vigo
Abel, J. A.	South Bend	St. Joseph	Allen, Robert K.	Indianapolis	Marion
Abel, Robert	Wakarusa	Elkhart	Allen, Robert T.	Richmond	Wayne-Union
Abell, Charles F.	Marion	Grant	Almquist, C. O.	Gary	Lake
Abreu, Benedict E.	Indianapolis	Marion	Altier, W. H.	Fowler	Benton
Acher, Robert P.	Greensburg	Decatur	Alvey, Charles R.	Muncie	Delaware-Blackford
Acker, Robert B.	South Bend	St. Joseph			
Acos, James C.	East Chicago	Lake	Alvis, Edmond O.	Indianapolis	Marion
Acre, R. R.	Evansville	Vanderburgh	Alward, John Haney	Kokomo	Howard
Adair, Fred L. (H)	Maitland, Fla.	Porter	Ambrose, J. C.	Noblesville	Hamilton
Adair, Samuel L.	Jeffersonville	Clark	Amick, Charles L.	Wakarusa	Elkhart
Adair, Wm. K.	Crothersville	Jackson	Amini, Sohrab	Huntingburg	Dubois
Adams, Charles J.	Kokomo	Howard	Amos, R. L.	New Castle	Henry
Adams, Max R.	Flora	Carroll	Amstutz, Henry C.	Goshen	Elkhart
Adams, William B.	Muncie	Delaware-Blackford	Amy, W. E.	Corydon	Harrison-Crawford
Adamski, Michael S.	Logansport	Cass	Anderson, Dwight	Evansville	Vanderburgh
Ade, C. H.	Lafayette	Tippecanoe	Anderson, R. M.	Vincennes	Knox
Ade, Mary	Lafayette	Tippecanoe	Anderson, Walter C.	Terre Haute	Vigo
Adkins, H. C.	Indianapolis	Marion	Anderson, Wendell C.	Indianapolis	Marion
Adkins, Onan C.	Indianapolis	Marion	Annis, Homer B.	Bluffton	Wells
Adler, David L.	Columbus	Bartholomew-Brown	Antes, Earl H.	Evansville	Vanderburgh
Adler, Edmund R.	Dyer	Lake	Appel, Richard H.	Indianapolis	Marion
Adler, Raymond N.	Evansville	Vanderburgh	Apple, Eddie R.	Salem	Washington
Adney, Frank B., Jr.	Richmond	Wayne-Union	Applegate, Albert E.	Frankfort	Clinton
Agee, Ernest B., Jr.	Terre Haute	Vigo	Arbeiter, Herbert I.	Hammond	Lake
Aiken, Arthur F.	Ft. Wayne	Allen	Arbogast, J. L.	Indianapolis	Marion
Aiken, Milo M.	Plainfield	Hendricks	Arbogast, Paul B.	Vincennes	Knox
Aiken, N. E.	Ft. Wayne	Allen	Arbonies, William G.	Terre Haute	Vigo
Ake, Loren	Richmond	Wayne-Union	Arbuckle, Wm. E.	Indianapolis	Marion
Albertson, F. P.	Indianapolis	Marion	Arisman, R. K.	South Bend	St. Joseph
Alcorn, Merritt O.	Madison	Jefferson-Switzerland	Arlook, Theodore D.	Elkhart	Elkhart
			Armalavage, Leon T.	Gary	Lake
Alderfer, Henry	Marion	Grant	Armington, C. L.	Anderson	Madison
Aldrich, Harry	Indianapolis	Marion	Armington, John C. (S)	Anderson	Madison
Aldrich, Howard	Indianapolis	Marion	Armington, Robert	Anderson	Madison
Alexander, Ezra D.	Indianapolis	Marion	Armstrong, T. D.	Michigan City	La Porte
Alexander, H. H.	Princeton	Gibson	Arnett, A. C.	Lafayette	Tippecanoe
Alexander, J. E.	Evansville	Vanderburgh	Arnold, Aaron L.	Indianapolis	Marion
Alexander, O. O.	Terre Haute	Vigo	Arnold, M. F.	East Chicago	Lake
Alexander, P. M.	Martinsville	Morgan	Arnold, Robert D.	Indianapolis	Marion
Alexander, Stephen J.	Crawfordsville	Montgomery	Aronson, Sidney S.	Indianapolis	Marion
Alford, James	Hamilton	Steuben	Arrowsmith, James L.	Hammond	Lake
Allegretti, Michael	Hammond	Lake	Arthur, H. M. (S)	Hazelton	Gibson
Allen, Fred K.	New Albany	Floyd	Arthur, Nora M.	Washington	Daviess-Martin
Allen, Hubert E.	Richmond	Wayne-Union			
Allen, J. L. (S)	Greenfield	Hancock	Asbury, W. D. (S)	Terre Haute	Vigo
Allen, L. Howard	Bedford	Lawrence	Ash, H. H.	W. Lafayette	Tippecanoe
			Asher, E. O.	New Augusta	Marion

Name	City	County	Name	City	County
Asher, James W.	New Augusta	Marion	Barton, W. M.	Centerville	Wayne-Union
Atchison, Kenneth C.	Rockport	Spencer	Bartsch, Harvey L.	South Bend	St. Joseph
Atkins, C. C.	Rushville	Rush	Bash, Wallace E.	Fort Wayne	Allen
Atkinson, C. W.	Boswell	Benton	Baskett, R. J.	Jonesboro	Grant
Aucreman, C. J.	Bluffton	Wells	Bassett, Clancy	Thorntown	Boone
Ault, Carl H.	Kokomo	Howard	Bassett, Margaret	Thorntown	Boone
Ault, Roy, Jr.	Terre Haute	Vigo	Bassler, C. R.	Mishawaka	St. Joseph
Austin, Charles E.	Anderson	Madison	Bates, George	Marion	Grant
Austin, Eugene W.	Evansville	Vanderburgh	Batman, Gordon W.	Indianapolis	Marion
Austin, F. H. (S)	Bloomington	Owen-Monroe	Battersby, J. Stanley	Indianapolis	Marion
Austin, M. A. (S)	Anderson	Madison	Batties, Paul A.	Indianapolis	Marion
Austin, R. P.	Bedford	Lawrence	Bauer, A. J.	Lafayette	Tippecanoe
Auten, Donald S.	Gary	Lake	Bauer, Thomas B.	Indianapolis	Marion
Ayres, Kenneth D.	Anderson	Madison	Baughn, William L.	Anderson	Madison
Ayres, W. W.	Marion	Grant	Baum, Harry	Indianapolis	Marion
<b>B</b>			Baumeister, Herbert E.	Indianapolis	Marion
Babb, Forrest J.	Stockwell	Tippecanoe	Baumgartner, Jeraldine	Fort Wayne	Allen
Bachmann, Arnold J.	Indianapolis	Marion	Baxter, J. W., Jr.	New Albany	Floyd
Backer, Henry G.	Ferdinand	Dubois	Baxter, Neal	Bloomington	Owen-Monroe
Badders, A. C.	Portland	Jay	Baxter, Samuel M.	New Albany	Floyd
Bahr, Max A. (S)	Indianapolis	Marion	Bayley, William E.	Lafayette	Tippecanoe
Bailey, Edwin B.	Linton	Greene	Baylor, Edward M.	Evansville	Vanderburgh
Bailey, E. W.	Logansport	Cass	Baynes, Frank L.	Wolcott	White
Bailey, L. S.	Zionsville	Boone	Beach, Robert R.	Indianapolis	Marion
Bailey, Orville T.	Indianapolis	Marion	Beam, Vernon B.	East Chicago	Lake
Bailey, Paul P.	Fort Wayne	Allen	Beams, Ralph H.	Fort Wayne	Allen
Bailey, Wm. A. (S)	Vincennes	Knox	Bean, Joseph S.	Indianapolis	Marion
Baitinger, H. M.	Gary	Lake	Bear, L. H. (S)	Vevay	Jefferson-Switzerland
Bakemeier, O. H.	Indianapolis	Marion	Beardsley, Frank A.	Frankfort	Clinton
Baker, A. M.	New Albany	Floyd	Beardsley, John	Frankfort	Clinton
Baker, G. D.	Crandall	Harrison-Crawford	Beasley, T. J.	Indianapolis	Marion
Baker, Herman	Evansville	Vanderburgh	Beaver, Ernest R.	Rensselaer	Jasper-Newton
Baker, J. S. (S)	Evansville	Vanderburgh	Beaver, Howard W.	Indianapolis	Marion
Baker, Leslie M.	Aurora	Dearborn-Ohio	Beaver, Norman	Berne	Adams
Baker, Mason R.	Evansville	Vanderburgh	Bechtol, Lavon D.	Whiting	Lake
Baker, Robert E. (S)	Orleans	Orange	Bechtold, S. E.	South Bend	St. Joseph
Baker, Warren	Michigan City	LaPorte	Beck, Evert M.	Indianapolis	Marion
Balch, James F.	Indianapolis	Marion	Beck, H. A.	Lebanon	Boone
Baldrige, W. O.	Terre Haute	Vigo	Beck, Robert E.	Evansville	Vanderburgh
Baldwin, J. H. (S)	Jeffersonville	Clark	Becker, Philip H.	Crown Point	Lake
Balkema, Cath. M.	Lafayette	Tippecanoe	Beckes, Norman E. (S)	Vincennes	Knox
Ball, Clay A.	Muncie	Delaware-Blackford	Beckman, H. F. (S)	Indianapolis	Marion
Ball, John R.	Indianapolis	Marion	Beconovich, Robert	Hammond	Lake
Ball, Joseph E.	Indianapolis	Marion	Bedwell, Marion H.	Sullivan	Sullivan
Ball, Phillip	Muncie	Delaware-Blackford	Beeler, J. Moss	Lafayette	Tippecanoe
Ball, T. Z. (S)	Crawfordsville	Montgomery	Beeler, John W.	Indianapolis	Marion
Balla, Morris	South Bend	St. Joseph	Beeler, Raymond C.	Indianapolis	Marion
Ballard, C. A.	Logansport	Cass	Beetem, L. F.	Madison	Jefferson-Switzerland
Ballard, Robert J.	Lebanon	Boone	Begley, Joseph W., Jr.	Evansville	Vanderburgh
Ballas, William A.	Evansville	Vanderburgh	Beggs, L. F.	Columbus	Bartholomew-Brown
Ballenger, W. E.	Richmond	Wayne-Union	Behn, Walter M.	Gary	Lake
Balsbaugh, George	N. Manchester	Wabash	Behnke, Roy H.	Indianapolis	Marion
Baltes, Joseph H.	Fort Wayne	Allen	Beierlein, Karl	Fort Wayne	Allen
Banister, R. F.	Indianapolis	Marion	Beilke, Clifford A.	East Chicago	Lake
Bankoff, Milton L.	Michigan City	LaPorte	Benchik, Frank A.	East Chicago	Lake
Banks, H. M.	Indianapolis	Marion	Bender, Cecil K.	Goshen	Elkhart
Baran, Charles	South Bend	St. Joseph	Bender, Robert L.	Elkhart	Elkhart
Barclay, I. C.	Evansville	Vanderburgh	Bendler, Carl H.	Gary	Lake
Bard, Frank B.	Crothersville	Jackson	Benedek, Tibor	East Chicago	Lake
Barnes, Helen B.	Greenwood	Johnson	Benedict, Charles D.	LaGrange	LaGrange
Barnett, R. E.	Peru	Miami	Benham, L. E.	Bedford	Lawrence
Barnhart, Willard T.	Evansville	Vanderburgh	Bennett, Abner P.	Evansville	Vanderburgh
Barnum, Emerson	Shelbyville	Shelby	Bennett, J. B.	Warren	Huntington
Barone, Carmelo V.	Mishawaka	St. Joseph	Bennett, Jene R.	South Bend	St. Joseph
Barron, Elmer A.	East Chicago	Lake	Benninghoff, D. R.	Fort Wayne	Allen
Barrow, John H.	Dale	Spencer	Benoit, Merrill T.	Anderson	Madison
Barry, M. J.	Indianapolis	Marion	Benz, Jesse	Marengo	Harrison-Crawford
Bartholomew, Mary	Goshen	Elkhart	Benz, O. F.	Wanatah	LaPorte
Bartle, J. Leo	Indianapolis	Marion	Bergan, Joseph A.	McKinney, Tex.	Lake
Bartley, Max D.	Indianapolis	Marion	Bergendahl, Emil H.	Fort Wayne	Allen
Barton, Robert	Angola	Steuben			



Name	City	County	Name	City	County
Berger, Henry I.	Indianapolis	Marion	Bond, Charles S. (S)	Richmond	Wayne-Union
Berger, Morley	Beech Grove	Marion	Bond, George S.	Indianapolis	Marion
Berghoff, Raymond	Fort Wayne	Allen	Bond, Virginia	Indianapolis	Marion
Bergenwall, Warren L.	Indianapolis	Marion	Bond, Walter	Clay City	Clay
Berke, Robert	South Bend	St. Joseph	Booher, Norman R.	Indianapolis	Marion
Berkebile, J. B.	Peru	Miami	Booher, Olga	Indianapolis	Marion
Berman, Edward J.	Indianapolis	Marion	Booth, Boynton H.	Indianapolis	Marion
Berman, Jacob K.	Indianapolis	Marion	Bopp, Henry, Jr.	Terre Haute	Vigo
Bernoske, D. G.	Michigan City	LaPorte	Bopp, Henry W.	Terre Haute	Vigo
Bethea, Dennis	Hammond	Lake	Bopp, James	Terre Haute	Vigo
Bethea, Robert O.	Farmersburg	Sullivan	Borak, Walter J.	Gary	Lake
Berton, William M.	Durham, N.C.	Marion	Borders, Theo. R.	Fort Wayne	Allen
Beverland, M. E.	Indianapolis	Marion	Boren, Paul	Poseyville	Posey
Biasini, Benedict A.	South Bend	St. Joseph	Boren, Samuel W. (S)	Poseyville	Posey
Bibler, Henry E.	Muncie	Delaware-Blackford	Borland, R. M.	Bloomington	Owen-Monroe
Bibler, L. D.	Indianapolis	Marion	Borough, L. D	South Bend	St. Joseph
Bickel, David A.	South Bend	St. Joseph	Bosenbury, Charles S. (S)	South Bend	St. Joseph
Bickel, J. E. (S)	Fort Wayne	Allen	Bosler, Howard A.	Waterford Mills	Elkhart
Bidney, Evelyn B.	Bloomington	Owen-Monroe		Mail Goshen	
Bigelow, O. P.	Roanoke	Huntington	Boswell, Robert W.	Evansville	Vanderburgh
Bigler, Frederick	Goshen	Elkhart	Bothwell, C. G.	Martinsville	Morgan
Billings, Elmer R.	Elkhart	Elkhart	Botkin, Clyde G.	Muncie	Delaware-Blackford
Billman, Gustus S.	Shelbyville	Shelby			
Bills, L. F.	Culver	Marshall	Botkin, Thomas	Muncie	Delaware-Blackford
Bills, R. N.	Gary	Lake			
Bird, Chas. R. (S)	Indianapolis	Marion	Bottorff, David C.	Charlestown	Clark
Birdzell, John P.	Crown Point	Lake	Boughman, Joseph D.	Kokomo	Howard
Birmingham, P. J.	South Bend	St. Joseph	Bowdoin, G. E.	Elkhart	Elkhart
Bishop, Charles A.	South Bend	St. Joseph	Bowen, Otis R.	Bremen	Marshall
Bishop, Harry A.	Frankton	Madison	Bowers, Copeland C.	Kokomo	Howard
Bissonnette, Roger P.	Evansville	Vanderburgh	Bowers, Don D.	Indianapolis	Marion
Bitler, C. C.	New Castle	Henry	Bowers, G. T.	Fort Wayne	Allen
Bivin, James H.	Indianapolis	Marion	Bowers, Garvey B.	Kokomo	Howard
Bixler, Donald P.	Anderson	Madison	Bowers, John A.	Kokomo	Howard
Bixler, Louis C.	South Bend	St. Joseph	Bowers, J. W.	Fort Wayne	Allen
Bjorklund, C. Ray	Hobart	Lake	Bowman, Charles M.	Albion	Noble
Black, C. S.	Warren	Huntington	Bowman, George W.	Indianapolis	Marion
Black, Edgar K.	Wabash	Wabash	Bowman, Harold E.	Indianapolis	Marion
Black, Joe M.	Seymour	Jackson	Boyd, C. L. (S)	Vincennes	Knox
Blackburn, Erwin	South Bend	St. Joseph	Boyd, Charles S.	East Chicago	Lake
Bland, H. E. (S)	Fairbanks	Sullivan	Boyd, Clarence E.	West Baden	Orange
Blassaras, Chris	Anderson	Madison	Boyd, Stella N.	Evansville	Vanderburgh
Blatt, A. E.	Indianapolis	Marion	Boyer, E. B.	Indianapolis	Marion
Blazey, A. G.	Washington	Daviess-Martin	Boyer, Floyd A.	Indianapolis	Marion
			Boyer, Grace B.	Marion	Grant
Bledsoe, James G.	New Castle	Henry	Boys, F. F.	East Chicago	Lake
Blemker, Russell M.	Greensburg	Decatur	Bradley, Stephen C.	Terre Haute	Vigo
Blessinger, Louis Henry	Corydon	Harrison-Crawford	Brady, Samuel	Gary	Lake
			Brady, Thomas A.	Indianapolis	Marion
Blessinger, Paul J.	Jasper	Dubois	Brandman, Harry	Gary	Lake
Blix, Fred M.	Ladoga	Montgomery	Brauchla, C. H.	Anderson	Madison
Bloemker, E. F.	Indianapolis	Marion	Brauer, Abraham A.	East Chicago	Lake
Bloom, Asa Ward	Marion	Grant	Braun, Benjamin D.	Chicago, Ill.	Lake
Bloom, George R.	Elkhart	Elkhart	Braunlin, Robert F.	Marion	Grant
Bloomer, J. R.	Rockville	Parke-Vermillion	Braunlin, W. H.	Marion	Grant
			Brayton, John R.	Indianapolis	Marion
Bloomer, R. S.	Rockville	Parke-Vermillion	Brayton, Lee	Indianapolis	Marion
			Brazelton, O. T.	Princeton	Gibson
Blosser, B. A.	Fremont	Steuben	Brechtol, Harvey J.	South Bend	St. Joseph
Blosser, H. V. (S)	Fort Wayne	Allen	Brenner, I. E.	Winchester	Randolph
Blossom, Paul W.	Richmond	Wayne-Union	Bretz, John M.	Huntingburg	Dubois
			Brickley, H. D.	Bluffton	Wells
Blum, Leon L.	Terre Haute	Vigo	Brickley, Richard A.	Bluffton	Wells
Boardman, Carl	Gary	Lake	Bridges, William L.	Indianapolis	Marion
Boaz, John J. (S)	Indianapolis	Marion	Bridwell, Edgar	Bedford	Lawrence
Bock, Don G.	Indianapolis	Marion	Briggs, Carl F.	Sullivan	Sullivan
Bodnar, Leslie M.	South Bend	St. Joseph	Briggs, Robert W.	Bridgeport	Marion
Bogardus, C. R.	Austin	Scott	Brink, Calvin C.	Gary	Lake
Boggs, E. F.	Indianapolis	Marion	Brincko, John	Indianapolis	Marion
Bohner, C. B.	Indianapolis	Marion	Briscoe, C. E. (S)	New Albany	Floyd
Bolin, John T.	Cedar Lake	Lake	Britton, W. D.	Montezuma	Parke-Vermillion
Bolin, Robert S.	Elkhart	Elkhart			
Boling, Grover C., Jr.	Indianapolis	Marion	Brock, Earl E.	Anderson	Madison
Bolka, B. J.	South Bend	St. Joseph			
Bolman, Ralph M.	Fort Wayne	Allen			
Bonaventura, A. P.	East Chicago	Lake			

Name	City	County	Name	City	County
Brockman, Wilfred	Corydon	Harrison-Crawford	Burdette, Harold F.	Indianapolis	Marion
Brockmeier, Frederick	Indianapolis	Marion	Burge, A. D. (S)	Marion	Grant
Brockmole, Arnold W.	Evansville	Vanderburgh	Burghard, D. Rolla	Indianapolis	Marion
Brodie, Donald W.	Indianapolis	Marion	Burk, James M.	Decatur	Adams
Bronson, Paul J.	Terre Haute	Vigo	Burket, Cecil R.	Bremen	Marshall
Brooks, H. L.	Michigan City	LaPorte	Burkhardt, B. A.	Tipton	Tipton
Broomes, Edward L. C.	East Chicago	Lake	Burkle, J. C.	Lafayette	Tippecanoe
Broshears, Kenneth	Linton	Greene	Burks, Jess E.	Crawfordsville	Montgomery
Brosius, Robert H. W.	Ft. Wayne	Allen	Burman, Richard G.	Jeffersonville	Clark
Brown, A. E.	Indianapolis	Marion	Burnett, Arthur B.	New Castle	Henry
Brown, D. B.	Gary	Lake	Burney, Leroy E.	Indianapolis	Marion
Brown, David E.	Indianapolis	Marion	Burnikel, Ray H.	Milwaukee, Wis.	Vanderburgh
Brown, Dewitt W.	Indianapolis	Marion	Burns, Paul E.	Montpelier	Delaware-Blackford
Brown, Edward A. (S)	Indianapolis	Marion	Burruss, B. O. (S)	Washington	Daviess-Martin
Brown, Frances T.	Indianapolis	Marion	Burris, F. L.	Michigan City	LaPorte
Brown, Frederick R.	Ellettsville	Owen-Monroe	Burroughs, C. A.	Frankfort	Clinton
Brown, Frederic W.	Ft. Wayne	Allen	Burrous, E. Lee	Peru	Miami
Brown, George E.	Greenwood	Johnson	Burwell, Stanley W.	Muncie	Delaware-Blackford
Brown, James A., Sr.	Evansville	Vanderburgh	Bush, Hargis R.	Cannelton	Perry
Brown, James C.	Valparaiso	Porter	Bussard, C. F.	South Bend	St. Joseph
Brown, James M.	Anderson	Madison	Bussard, Frank	South Bend	St. Joseph
Brown, J. S.	Carlisle	Sullivan	Butler, John O.	Indianapolis	Marion
Brown, K. H.	New Albany	Floyd	Butler, Robert M.	Indianapolis	Marion
Brown, Leland G.	Muncie	Delaware-Blackford	Butterfield, Robt. M.	Muncie	Delaware-Blackford
Brown, Leo R.	Gary	Lake	Buttz, Rose J.	Indianapolis	Marion
Brown, Marcel S.	Spencer	Owen-Monroe	Byrn, H. W.	New Albany	Floyd
Brown, R. E.	Cayuga	Parke-Vermillion	Byrne, John M.	Delphi	Carroll
Brown, R. L.	Colo. Springs, Colo.	Vanderburgh	Byrne, Robert J.	Bicknell	Knox
Brown, Robert R.	Terre Haute	Vigo	<b>C</b>		
Brown, Robert M.	Marion	Grant	Cacia, John J.	Evansville	Vanderburgh
Brown, Stanley L.	Hammond	Lake	Cahal, Ernest	Indianapolis	Marion
Brown, Stewart D.	Albany	Delaware-Blackford	Cahn, Hugo M.	Indianapolis	Marion
Brown, Thomas	Delphi	Carroll	Cajacob, Melville E.	Terre Haute	Vigo
Brown, Thomas M.	Muncie	Delaware-Blackford	Caldwell, Marilyn	Indianapolis	Marion
Brown, Wendell E.	Indianapolis	Marion	Caldwell, Milton V.	Terre Haute	Vigo
Browning, J. S.	Indianapolis	Marion	Caldwell, William C.	Evansville	Vanderburgh
Browning, W. M.	Indianapolis	Marion	Call, Earle B.	Knightstown	Henry
Brubaker, Harold S.	Huntington	Huntington	Call, H. F.	Indianapolis	Marion
Brubaker, O. G. (S)	N. Manchester	Wabash	Callaghan, W. C.	Greensburg	Decatur
Bruegge, T. J.	Kokomo	Howard	Callahan, R. H.	East Chicago	Lake
Bruetsch, Walter L.	Indianapolis	Marion	Calli, Louis	North Vernon	Jennings
Bruggeman, H. O.	Ft. Wayne	Allen	Calvert, R. R.	Lafayette	Tippecanoe
Bruner, Ralph	Jeffersonville	Clark	Calvin, Jessie C. (S)	Ft. Wayne	Allen
Brunoehler, Carl J.	Muncie	Delaware-Blackford	Cameron, D. F.	Ft. Wayne	Allen
Bryan, F. A.	Ft. Wayne	Allen	Campagna, E. A.	East Chicago	Lake
Bryan, Robert E.	Kendallville	Noble	Campbell, Guy G.	Munster	Lake
Bryan, Robert J.	South Bend	St. Joseph	Campbell, J. A.	Indianapolis	Marion
Bryan, S. L.	Evansville	Vanderburgh	Campbell, P. A.	Richmond	Wayne-Union
Buchanan, W. D.	South Bend	St. Joseph	Campbell, Sam W.	Noblesville	Hamilton
Buche, F. P.	Richmond	Wayne-Union	Canaday, C. E. (S)	New Castle	Henry
Buchholz, Ransom R.	Evansville	Vanderburgh	Canaday, J. W. (S)	Indianapolis	Marion
Buck, Charles E.	Indianapolis	Marion	Cannon, Daniel H.	New Albany	Floyd
Buckingham, Richard	Bloomington	Owen-Monroe	Caplin, Irvin	Indianapolis	Marion
Buckles, David L.	Anderson	Madison	Caplin, S. S.	Indianapolis	Marion
Buckley, E. P.	Jeffersonville	Clark	Carbone, J. A.	Gary	Lake
Buckner, Doster	Ft. Wayne	Allen	Carey, W. W. (S)	Ft. Wayne	Allen
Buckner, George D.	Fort Wayne	Allen	Carlberg, D. L.	Jeffersonville	Clark
Buckner, Joy F.	Bluffton	Wells	Carleton, E. H.	East Chicago	Lake
Buechner, F. W.	South Bend	St. Joseph	Carlo, Ernest R.	Ft. Wayne	Allen
Buehner, Donald F.	Evansville	Vanderburgh	Carlo, J. F.	Hammond	Lake
Buhrmester, H. C.	Lafayette	Tippecanoe	Carlson, Charles E.	Indianapolis	Marion
Buikstra, C. R.	Evansville	Vanderburgh	Carlson, E. A. (S)	Peru	Miami
Bullard, Mattie J.	Gary	Lake	Carlson, Norman C.	Michigan City	LaPorte
Bulson, Eugene L.	Ft. Wayne	Allen	Carlyle, Ivan E.	Michigantown	Clinton
Bunde, Carl	Indianapolis	Marion	Carmichael, C. S. (S)	Seelyville	Vigo
Bunker, L. Z.	N. Manchester	Wabash	Carmody, R. F.	Gary	Lake
Burcham, J. B.	Gary	Lake	Carneal, Thomas E.	Winamac	Pulaski
			Carney, J. T.	Jeffersonville	Clark
			Carney, John C.	Monticello	White
			Carpenter, G. C.	Terre Haute	Vigo
			Carpenter, J. L.	Alexandria	Madison



Name	City	County	Name	City	County
Carpenter, Thomas D.	Columbus	Bartholomew-	Coffel, Melvin H.	Vincennes	Knox
		Brown	Coffman, Delmar Lee	Clinton, Okla.	Vanderburgh
Carpentier, Harry F.	Princeton	Gibson	Cohn, Alvin C.	Indianapolis	Marion
Carrel, Francis E.	Frankfort	Clinton	Cohen, Irving	Plainfield	Hendricks
Carroll, John C.	Decatur	Adams	Cole, A. V.	East Chicago	Lake
Carroll, Bertha Rose	W. Lafayette	Tippecanoe	Cole, Ira	Lafayette	Tippecanoe
Carroll, Mary E.	Crown Point	Lake	Cole, Russel E.	Muncie	Delaware-
Carson, Wayne	Indianapolis	Marion			Blackford
Carter, F. R. Nicholas	South Bend	St. Joseph	Coleman, Floyd B.	Waterloo	Dekalb
Carter, Fred S.	LaPorte	LaPorte	Coleman, H. G.	Odon	Daviess-
Carter, James C.	Indianapolis	Marion			Martin
Carter, J. V.	Tipton	Tipton	Coleman, Joseph E.	Evansville	Vanderburgh
Carter, Oren E.	Indianapolis	Marion	Colglazier, G. G.	Leipsic	Orange
Cartwright, E. L.	Ft. Wayne	Allen	Colip, George	South Bend	St. Joseph
Cartwright, Jack D.	LaPorte	LaPorte	Collins, Hubert L.	Indianapolis	Marion
Casebeer, P. B.	Clinton	Parke-	Collins, J. N.	Indianapolis	Marion
		Vermillion	Combs, Charles N.	Terre Haute	Vigo
Caseley, Donald	Chicago, Ill.	Marion	Combs, Herman	Evansville	Vanderburgh
Casey, Stanley M.	Huntington	Huntington	Combs, John H.	Evansville	Vanderburgh
Cassady, J. V.	South Bend	St. Joseph	Combs, Loyal	Lowell	Lake
Catlett, M. B.	Ft. Wayne	Allen	Combs, Nelson B.	Mulberry	Clinton
Cavins, A. W.	Terre Haute	Vigo	Combs, Pearl B.	Evansville	Vanderburgh
Cavitt, Robert F.	Connersville	Fayette-	Combs, Stuart R.	Terre Haute	Vigo
		Franklin	Comeau, Wm. J.	Marion	Grant
Cayley, Frank J.	Indianapolis	Marion	Comer, Charles W.	Mooreville	Morgan
Caylor, Harold D.	Bluffton	Wells	Comer, Kenneth E.	Mooreville	Morgan
Caylor, Truman E.	Bluffton	Wells	Compton, C. B.	Frankfort	Clinton
Challman, W. B.	Mt. Vernon	Posey	Compton, George	Tipton	Tipton
Chambers, A. R.	Ft. Wayne	Allen	Compton, Walter A.	Elkhart	Elkhart
Chambers, L. B.	Union City	Randolph	Condit, David H.	South Bend	St. Joseph
Chambers, William	Cincinnati, O.	St. Joseph	Congleton, G. C.	Terre Haute	Vigo
Chandler, L. H.	Millersburg	Elkhart	Conklin, James O.	Terre Haute	Vigo
Chappell, Harold R.	Oakland City	Gibson	Conklin, R. L.	Elkhart	Elkhart
Chattin, Herbert O.	Vincennes	Knox	Conley, John E.	Ft. Wayne	Allen
Chattin, Robert E.	Loogootee	Daviess-Martir	Conley, Joseph L.	Indianapolis	Marion
Chattin, William R.	Indianapolis	Marion	Conley, T. M.	Kokomo	Howard
Chattin, V. J.	Washington	Daviess-Martir	Connell, P. S.	Plymouth	Marshall
Chen, K. K.	Indianapolis	Marion	Connell, Victor O.	Bourbon	Marshall
Chevigny, J. J.	Gary	Lake	Conner, T. E. (S)	Freetown	Jackson
Chidlaw, B. W.	Hammond	Lake	Connerly, M. L.	San Diego,	Marion
Childs, A. G. W. (S)	Madison	Jefferson-		Calif.	
		Switzerland	Connoy, Andrew F.	Westfield	Hamilton
Childs, Wallace E.	Madison	Jefferson-	Connoy, Leo	Westfield	Hamilton
		Switzerland	Conrad, E. M. (S)	Anderson	Madison
Chittick, A. G.	Frankfort	Clinton	Conrad, Henry W.	Milan	Ripley
Christian, William A.	Indianapolis	Marion	Conway, Chester C.	Indianapolis	Marion
Christophel, Verna	Mishawaka	St. Joseph	Conway, Glenn	Indianapolis	Marion
Chroniak, Walter	Indianapolis	Marion	Cook, C. J. (S)	Indianapolis	Marion
Clancy, J. F.	Hammond	Lake	Cook, Charles E.	North	
Clark, C. P.	Indianapolis	Marion		Manchester	Wabash
Clark, Cyrus J.	Indianapolis	Marion	Cook, Elbert C. (S)	Bradenton,	Jefferson-
Clark, Fred O.	Syracuse	Kosciusko		Fla.	Switzerland
Clark, Ivan A.	Paoli	Orange	Cook, G. M.	Hammond	Lake
Clark, Lawson J.	Indianapolis	Marion	Cook, Gordon C.	South Bend	St. Joseph
Clark, M. E.	Cambridge	Wayne-Union	Cook, Norman R.	Richmond	Wayne-Union
	City		Cook, Robert G.	Bluffton	Wells
Clark, Stanley A. (S)	South Bend	St. Joseph	Cooksey, T. L. (S)	Crawfordsville	Montgomery
Clark, William B., Jr.	Jeffersonville	Clark	Cooney, Charles J.	Ft. Wayne	Allen
Clark, Wm. H.	South Bend	St. Joseph	Coons, John D.	Lebanon	Boone
Clark, W. R.	Ft. Wayne	Allen	Coons, Ritchie	Lebanon	Boone
Clarke, Elton R.	Kokomo	Howard	Cooper, H. L.	South Bend	St. Joseph
Clauser, E. H.	Muncie	Delaware-	Cooper, Leo Kenneth	Gary	Lake
		Blackford	Cooper, Thomas L.	Logansport	Cass
Clements, A. F.	Evansville	Vanderburgh	Cope, Stanton E.	Huntington	Huntington
Cleveland, John B.	LaPorte	LaPorte	Copeland S. J. (S)	Indianapolis	Marion
Clevenger, J. H.	Muncie	Delaware-	Corcoran, Patrick J. V.	Evansville	Vanderburgh
		Blackford	Cormican, Herbert L.	Elkhart	Elkhart
Clevinger, Wm. G.	Indianapolis	Marion	Cornacchione, M.	Indianapolis	Marion
Cline, Kenneth L.	Wyatt	St. Joseph	Cornell, Beaumont S.	Ft. Wayne	Allen
Close, W. D.	Indianapolis	Marion	Cornell, Robert A.	Crawfordsville	Montgomery
Clouse, Paul A.	Evansville	Vanderburgh	Corpe, Kenneth F.	Rushville	Rush
Clunie, Wm. A.	Huntington	Huntington	Cortese, James V.	Indianapolis	Marion
Coble, F. H.	Richmond	Wayne-Union	Cortese, Thomas A.	Indianapolis	Marion
Coble, R. R.	Indianapolis	Marion	Cotter, E. R.	East Chicago	Lake
Cockrum, Wm. M.	Evansville	Vanderburgh	Cotton, S. M.	Goldsmith	Tipton
Coddens, A. L.	Earl Park	Benton	Coulson, S. B.	Waldron	Shelby
Cody, B. L.	Evansville	Vanderburgh	Coultas, P. J.	Tell City	Perry

Name	City	County	Name	City	County
Countryman, Frank W.	Topeka, Kan.	Marion	Dalton, Wilson L.	Shelbyville	Shelby
Courtney, John W.	Indianapolis	Marion	Dancer, C. R. (S)	Fort Wayne	Allen
Covalt, Wendell E.	Muncie	Delaware- Blackford	Dando, George H. (S)	Hartford City	Delaware- Blackford
Covell, H. M.	Auburn	Dekalb	Daniel, J. C.	Indianapolis	Marion
Cox, C. E.	Indianapolis	Marion	Danieleski, L. J.	Gary	Lake
Cox, Harold	Indianapolis	Marion	Daniels, E. O.	Marion	Grant
Cox, Leon T.	Richmond	Wayne-Union	Daniels, G. R.	Marion	Grant
Cox, W. T.	Lafayette	Tippecanoe	Dannacher, William D.	Wabash	Wabash
Coyner, A. B.	Lafayette	Tippecanoe	Dare, Lee A.	Jeffersonville	Clark
Craft, K. L.	Indianapolis	Marion	Darling, Dorothy	Gary	Lake
Craft, William F.	Linton	Greene	Darroch, S. C.	Cayuga	Parke- Vermillion
Craig, Alexander F.	New Castle	Henry	Dassell, Paul Milton	Maywood, Ill.	Lake
Craig, R. A.	Kokomo	Howard	Datzman, Richard C.	Fort Wayne	Allen
Craig, Reuben	Kokomo	Howard	Daubenheyer, M. F. (S)	Richmond	Wayne- Union
Craig, Robert A.	Syracuse	Kosciusko	Daugherty, F. N.	Crawfordsville	Montgomery
Craigmile, Thomas	Oakville	Delaware- Blackford	Daves, W. L.	Evansville	Vanderburgh
Crain, James Wm.	Williamsport	Fountain- Warren	Davidoff, Manuel A.	Ossian	Wells
Crampton, C. C. (S)	Delphi	Carroll	Davidson, N. Cort	Indianapolis	Marion
Crandall, Latham A.	Elkhart	Elkhart	Davies, Robert	New Castle	Henry
Craven, Howard	Indianapolis	Marion	Davis, Alice H.	Hammond	Lake
Crawford, James H.	Evansville	Vanderburgh	Davis, Carl M.	Valparaiso	Porter
Crawford, John A.	Indianapolis	Marion	Davis, E. C.	Muncie	Delaware- Blackford
Crawford, T. R.	Kokomo	Howard	Davis, Howard B.	Vincennes	Knox
Creel, Donald	Angola	Steuben	Davis, J. A.	Flat Rock	Shelby
Crevello, Albert J.	Evansville	Vanderburgh	Davis, John A.	Indianapolis	Marion
Crimm, Paul D.	Evansville	Vanderburgh	Davis, John C.	Logansport	Cass
Cring, George	Portland	Jay	Davis, Joseph B.	Marion	Grant
Cripe, E. P.	Bremen	Marshall	Davis, M. S.	Marion	Grant
Cripe, William	Portland	Jay	Davis, Marvin R.	Columbus	Bartholomew- Brown
Crockett, F. S.	Lafayette	Tippecanoe	Davis, Neal	Gary	Lake
Crossland, Stewart H.	Gary	Lake	Davis, Parvin M.	New Albany	Floyd
Crowder, James H., Jr.	Sullivan	Sullivan	Davis, Richard	Marion	Grant
Crum, Marion M.	Angola	Steuben	Davis, Sam J.	Indianapolis	Marion
Culbertson, C. S.	South Bend	St. Joseph	Davis, William	New Market	Montgomery
Culbertson, Clyde G.	Indianapolis	Marion	Day, George H.	New Albany	Floyd
Cullen, P. K.	Indianapolis	Marion	Day, Theodore P.	Willoughby, O.	Vigo
Cullipher, J. E. (S)	Elwood	Madison	Day, W. D. C.	Seymour	Jackson
Cullison, Charles W.	Vincennes	Knox	Deal, Eleanor H.	Speedway City	Marion
Cullnane, C. W.	Evansville	Vanderburgh	Dean, Donald I.	Rushville	Rush
Culloden, William G.	Indianapolis	Marion	Dearmin, R. M.	Indianapolis	Marion
Culmer, W. N. (S)	Bloomington	Owen- Monroe	DeArmond, Murray	Indianapolis	Marion
Culp, John E.	Ft. Wayne	Allen	Decker, H. B.	Terre Haute	Vigo
Cummings, D. J.	Brownstown	Jackson	DeDario, L. M.	Elkhart	Elkhart
Cunningham, J. M. (S)	Indianapolis	Marion	Deems, Myers B.	Evansville	Vanderburgh
Cunningham, Robert D.	Charleston, W. Va.	St. Joseph	Deever, J. W.	Indianapolis	Marion
Cure, Charles W.	Indianapolis	Marion	DeFries, John J.	New Paris	Elkhart
Cure, Elmer T.	Muncie	Delaware- Blackford	DeGrazia, E. J.	Valparaiso	Porter
Currie, Robert W.	Marion	Grant	DeMotte, C. Bowen	Indianapolis	Marion
Curry, Claude A.	Terre Haute	Vigo	DeMotte, Russell A.	Bloomington	Owen- Monroe
Curtner, M. L.	Vincennes	Knox	DeNaut, J. F.	Knox	Starke
Cusack, Robert	Santa Monica, Calif.	Marion	Denham, Robert H.	South Bend	St. Joseph
Custer, E. W.	South Bend	St. Joseph	Denman, R. D. (S)	Helmer	Steuben
Cuthbert, F. S. (S)	Kokomo	Howard	Denny, Edgar C.	Milton	Wayne- Union
Cuthbert, M. P.	Indianapolis	Marion	Denny, Fred C.	Madison	Jefferson- Switzerland
D			Denny, Forrest L.	Indianapolis	Marion
Daggy, James R.	Richmond	Wayne-Union	Denny, Frank T.	Ladoga	Montgomery
Dagley, Hubert	Columbus	Bartholomew- Brown	Denny, J. W.	Indianapolis	Marion
Dahling, C. W.	New Haven	Allen	Denny, Melvin H.	Rushville	Rush
Dailey, J. E.	Indianapolis	Marion	Denton, Larkin D.	Greentown	Howard
Dainko, A. J.	East Chicago	Lake	Denzer, E. K.	Evansville	Vanderburgh
Dale, J. W.	Chesterton	Porter	Denzer, Wm. Oliver	Evansville	Vanderburgh
Dale, Maxwell H.	Connersville	Fayette- Franklin	Deppe, Charles F.	Franklin	Johnson
Daley, Edward H.	Oldenburg	Fayette- Franklin	Derhammer, G. L.	Brookston	White
Dalton, John E.	Indianapolis	Marion	DeRyke, Gilbert R.	Winchester	Randolph
Dalton, Naomi	Bloomington	Owen- Monroe	DeJean, Paul A.	Indianapolis	Marion
Dalton, William W.	Indianapolis	Marion	Dester, Herbert E.	Jagdeeshpur, India	Marion
			DeTar, G. B. (S)	Winslow	Pike
			Detrick, H. W.	Hammond	Lake
			Dettloff, Frederick	Greencastle	Putnam



Name	City	County	Name	City	County
Dettman, John	Edinburg	Johnson	Duemling, Arnold H.	Ft. Wayne	Allen
Deutsch, Wm.	Muncie	Delaware- Blackford	Dugan, Thomas J. (S)	Indianapolis	Marion
DeVoe, Kenneth	Tacoma, Wash.	Allen	Dugan, Wm. M.	Indianapolis	Marion
DeWees, Dwight L.	Indianapolis	Marion	Duggan, J. A.	South Bend	St. Joseph
Dewey, Fred N. (S)	Elkhart	Elkhart	Dukes, Betty	Dugger	Sullivan
Dewey, Geo. W. (S)	Lafayette	Tippecanoe	Dukes, David A.	Tell City	Perry
DeWitt, C. H. (S)	Valparaiso	Porter	Dukes, F. M.	Dugger	Sullivan
Diamond, Leo	Marion	Grant	Dukes, Joe E.	Dugger	Sullivan
Dian, A. J.	Gary	Lake	Dulin, Basil B.	Indianapolis	Marion
Dian, Julia G. Kuzmitz	Gary	Lake	Dunbar, Colin V.	Indianapolis	Marion
Dickson, D. D.	Greensburg	Decatur	Duncan, J. S.	Gary	Lake
Dickinson, Gordon A.	Petersburg	Pike	Dunham, Wilbur F.	Kempton	Tipton
Dieckman, Herbert S.	Evansville	Vanderburgh	Dunlap, D. Logan	South Bend	St. Joseph
Diefendorf, Charles F. (S)	Evansville	Vanderburgh	Dunn, F. W.	Muncie	Delaware- Blackford
Dielman, F. C.	Fulton	Fulton	Dunning, L. M.	Indianapolis	Marion
Dierdorf, Fred	Winslow	Pike	Dunstone, H. C.	Ft. Wayne	Allen
Dierolf, Edward J.	Gary	Lake	Dupes, L. E.	Hobart	Lake
Dietl, E. L.	South Bend	St. Joseph	DuPuy, Charles M. (S)	Riley	Vigo
Dillman, Carl E.	Corydon	Harrison- Crawford	Durkee, M. S.	Evansville	Vanderburgh
Dilts, Robert	Indianapolis	Marion	Dusard, Joseph C.	Bedford	Lawrence
Dingle, Paul	Richmond	Wayne- Union	Dutchess, C. T.	Galveston	Cass
Dininger, W. S.	Winchester	Randolph	Dvorak, June A.	Indianapolis	Marion
Dintaman, Paul G.	Indianapolis	Marion	Dyar, E. W.	Indianapolis	Marion
Dittmer, J. E.	Kouts	Porter	Dycus, W. A.	Evansville	Vanderburgh
Dittmer, Thomas L.	Valparaiso	Porter	Dyer, G. W.	Terre Haute	Vigo
Ditton, I. W. (S)	Ft. Wayne	Allen	Dyer, Wallace K.	Evansville	Vanderburgh
Dixon, Rex	Anderson	Madison	Dyke, Richard W.	Indianapolis	Marion
Dobbs, O. R.	Greencastle	Putnam	Dykhuisen, T. A.	Frankfort	Clinton
Dodd, Robert D.	South Bend	St. Joseph		E	
Dodd, Roberts K.	Phila., Pa.	Vanderburgh	Eades, R. Charles	Westville	LaPorte
Dodds, James U.	Hartford City	Delaware- Blackford	Eades, Ralph C.	Valparaiso	Porter
Dodds, Wemple	Crawfordsville	Montgomery	Earl, Max M.	Kokomo	Howard
Doenges, James L.	Anderson	Madison	Earp, Evanson B.	Indianapolis	Marion
Dolezal, Bernard J.	South Bend	St. Joseph	Eastman, J. R., Jr.	Indianapolis	Marion
Dollens, Claude	Oolitic	Lawrence	Eaton, E. R.	Indianapolis	Marion
Dome, H. S. (S)	Tell City	Perry	Eaton, L. D.	Franklin	Johnson
Donahue, C. M.	Carmel	Hamilton	Eaton, M. J.	Lafayette	Tippecanoe
Donahue, G. R.	Lafayette	Tippecanoe	Ebbinghouse, Tom	Richmond	Wayne-Union
Donaldson, Frank C.	Anderson	Madison	Ebert, J. Wayne	Indianapolis	Marion
Donato, Albert M.	Indianapolis	Marion	Eberwein, J. H.	Indianapolis	Marion
Donchess, J. C.	Gary	Lake	Eby, Ida L.	Goshen	Elkhart
Donham, William L.	Bicknell	Knox	Ekert, Russell A.	Indianapolis	Marion
Donnelly, Everett F.	South Bend	St. Joseph	Edlavitch, B. M.	Ft. Wayne	Allen
Donner, Paul G.	Hartf'd, Conn.	Marion	Edmonds, Kendrick	Bedford	Lawrence
Donovan, S. J.	Michigan City	La Porte	Edwards, Bernard	South Bend	St. Joseph
Doran, J. Hal	Indianapolis	Marion	Edwards, Edward T., Jr.	Vincennes	Knox
Dorman, W. L.	Indianapolis	Marion	Edwards, W. F.	New Albany	Floyd
Dorrance, T. O.	Bluffton	Wells	Egan, Sherman	South Bend	St. Joseph
Doty, J. R.	Gary	Lake	Egbert, Clarence	Muncie	Delaware- Blackford
Douglas, G. R. (S)	Valparaiso	Porter	Egbert, Herbert	Indianapolis	Marion
Douglas, William T.	Montpelier	Delaware- Blackford	Egbert, Roy	Indianapolis	Marion
Dowd, Joseph A.	Indianapolis	Marion	Eggers, E. L.	Hammond	Lake
Dowell, E. H.	Rockville	Parke- Vermillion	Eggers, H. W.	Hammond	Lake
Downard, Leland F.	Gaston	Delaware- Blackford	Egnatz, Nicholas	Hammond	Lake
Dragoo, Farrol	Middletown	Henry	Ehrich, W. S.	Evansville	Vanderburgh
Drake, John C.	Anderson	Madison	Ehrman, C. D.	Rockport	Spencer
Drake, M. C.	Elwood	Madison	Eicher, Palmer	Indianapolis	Marion
Drake, William L.	Indianapolis	Marion	Eickenberry, H. W.	Indianapolis	Marion
Draper, M. H.	Tampa, Fla.	Allen	Eisaman, Jack L.	Bluffton	Wells
Dreyer, Ralph W.	Knightstown	Henry	Eisenberg, D. A.	Martinsville	Morgan
Dryden, Gale E.	Indianapolis	Marion	Eisenlohr, Eugen	Terre Haute	Vigo
Dublin, Madeline P.	Francesville	Pulaski	Eisterhold, John A.	Evansville	Vanderburgh
Dubois, F. T. (S)	Liberty	Wayne- Union	Eldridge, Gail E.	Indianapolis	Marion
Dubois, R. B.	Lafayette	Tippecanoe	Elledge, Ray	Hammond	Lake
Duckworth, Alda G.	Baltimore, Md.	Marion	Ellerbrook, George E.	Vevay	Jefferson- Switzerland
Dudding, J. E.	Hope	Bartholomew- Brown	Ellett, John, Jr.	Coatesville	Hendricks
			Elliott, John C.	Guilford	Dearborn- Ohio
			Elliott, L. A.	Elkhart	Elkhart
			Elliott, Paul W.	Danville	Hendricks
			Elliott, R. A.	Gary	Lake
			Elliott, R. H. (S)	Indianapolis	Marion
			Elliott, Thomas A.	Elkhart	Elkhart

Name	City	County	Name	City	County
Ellis, Bert	Indianapolis	Marion	Ferguson, A. N.	Little Rock, Ark.	Allen
Ellis, Davis W., Jr.	Rushville	Rush	Ferguson, John T.	Marion	Grant
Ellis, George M.	Connersville	Fayette-Franklin	Ferguson, Wm. B.	W. Lafayette	Marion
Ellis, Lyman H.	Lizton	Hendricks	Ferrara, Donald W.	Peru	Miami
Ellis, Seth	Anderson	Madison	Ferrara, Joseph F.	Franklin	Johnson
Ellison, Alfred	South Bend	St. Joseph	Ferrara, S. J.	Peru	Miami
Elshout, Clem H.	LaPorte	LaPorte	Ferrell, Jesse E.	Fortville	Hancock
Elsner, L. W.	Seymour	Jackson	Ferrell, Mars B.	Fortville	Hancock
Elsten, A. W.	Anderson	Madison	Ferry, John L.	Whiting	Lake
Elston, L. W.	Ft. Wayne	Allen	Ferry, P. W.	Kokomo	Howard
Elston, Ralph W.	Ft. Wayne	Allen	Fessler, G. S.	Rising Sun	Dearborn-Ohio
Emenhiser, Donald C.	New Haven	Allen	Fichman, A. M.	Fort Wayne	Allen
Emenhiser, John L.	Fort Wayne	Allen	Fickas, Dallas	Evansville	Vanderburgh
Emery, Charles B.	Bedford	Lawrence	Filipek, W. J.	South Bend	St. Joseph
Emhardt, J. W. A.	Indianapolis	Marion	Fincher, Robert C.	New Castle	Henry
Emhardt, John T.	Indianapolis	Marion	Fipp, August L.	Rome City	Noble
Emme, R. W.	Harlan	Allen	Firestein, Ben	South Bend	St. Joseph
Endicott, Wayne	Greenfield	Hancock	Firestein, Ray	Chicago, Ill.	St. Joseph
Engel, E. L.	Evansville	Vanderburgh	Fisch, Charles	Indianapolis	Marion
Engeler, J. E.	Lafayette	Tippecanoe	Fischer, Burnell	Hammond	Lake
Engle, J. M.	Portland	Jay	Fischer, C. N.	La Porte	La Porte
Engle, Russell B.	Winchester	Randolph	Fischer, W. E.	Anderson	Madison
Engleman, H. K.	Georgetown	Floyd	Fish, C. M.	South Bend	St. Joseph
English, H. M.	Gary	Lake	Fish, Edson C.	South Bend	St. Joseph
English, J. P.	South Bend	St. Joseph	Fisher, Gerald	Cleveland, O.	Marion
Ensminger, L. A.	Indianapolis	Marion	Fisher, Henry	Marion	Grant
Entner, Charles L.	Connersville	Fayette-Franklin	Fisher, John E.	Attica	Fountain-Warren
Enzor, O. K.	Indianapolis	Marion	Fisher, John E.	New Castle	Henry
Episcopo, A. R.	Salem	Washington	Fisher, Lawrence F.	South Bend	St. Joseph
Erdel, Milton W.	Frankfort	Clinton	Fisher, Walter S.	Columbus	Bartholomew-Brown
Erehart, A. D.	Anderson	Madison	Fisher, William C.	Evansville	Vanderburgh
Erehart, M. G.	Huntington	Huntington	Fisk, Frank B.	Indianapolis	Marion
Ericksen, Lester G.	South Bend	St. Joseph	Fitch, Ray T.	Muncie	Delaware-Blackford
Erickson, Gustaf W.	South Bend	St. Joseph	Fitzgerald, Brice E.	Logansport	Cass
Ericson, H. L.	Windfall	Tipton	Fitz Gerald, Maurice D.	Evansville	Vanderburgh
Ernst, Clifford	Indianapolis	Marion	Fitzgerald, William J.	Indianapolis	Marion
Ernst, H. C.	East Chicago	Lake	Fitzpatrick, Harry W.	Elwood	Madison
Eshleman, L. H. (S)	Marion	Grant	Fitzpatrick, James S.	Portland	Jay
Estes, Ambrose C.	Bloomington	Owen-Monroe	Fitzsimmons, E. L.	Evansville	Vanderburgh
Estlick, R. E.	Ft. Wayne	Allen	Flack, Russell A.	Lafayette	Tippecanoe
Evans, Frederick H.	Indianapolis	Marion	Flaherty, Walter T.	Michigan City	La Porte
Evans, Frederick J.	Clinton	Parke-Vermillion	Flanagan, E. P.	Walton	Cass
Evans, Paul V.	Indianapolis	Marion	Flanigan, M. B.	Indianapolis	Marion
Evans, R. M.	Russiaville	Howard	Flannigan, H. F.	LaGrange	LaGrange
Everly, Ralph	Indianapolis	Marion	Fleetwood, R. A.	Nappanee	Elkhart
Eviston, J. V.	Huntington	Huntington	Fleischer, J. C.	East Chicago	Lake
Ewbank, J. Nelson	Richmond	Wayne-Union	Fleming, C. F.	Elkhart	Elkhart
Ewing, Nathaniel D.	Vincennes	Knox	Fleming, Justus M.	Elkhart	Elkhart
F			Fletcher, Charles F.	Sunman	Ripley
Fagaly, W. J.	Lawrenceburg	Dearborn-Ohio	Flick, John J.	Indianapolis	Marion
Failey, Robert	Indianapolis	Marion	Flinn, John H.	Evansville	Vanderburgh
Fair, John R.	Augusta, Ga.	Noble	Flora, Joseph O.	Indianapolis	Marion
Faith, I. L.	Newburgh	Warrick	Fodor, Oscar	Seattle, Wash.	Shelby
Faltin, Ladislaus	South Bend	St. Joseph	Folck, J. K.	Princeton	Gibson
Farabee, Charles R.	North Judson	Starke	Folkening, N. C.	Indianapolis	Marion
Fargher, F. M.	Michigan City	La Porte	Foltz, Lloyd E.	Brownsburg	Hendricks
Fargher, R. A.	La Porte	La Porte	Forbes, Violet Crabbe	Wolcott	White
Farnsworth, S. A.	La Porte	La Porte	Foreman, Harry L.	Indianapolis	Marion
Farr, James	Martinsville	Morgan	Foreman, Walter A.	Brookville	Fayette-Franklin
Farrell, J. T.	Indianapolis	Marion	Forry, Frank	Indianapolis	Marion
Farris, John J.	Washington	Daviess-Martin	Forsee, Norman E.	Jeffersonville	Clark
Faul, Henry J.	Evansville	Vanderburgh	Forsyth, D. H. (S)	Terre Haute	Vigo
Faulkner, W. H.	Nashville, Tenn.	Wayne-Union	Fosbrink, E. L.	Syracuse	Kosciusko
Fausset, C. Basil	Indianapolis	Marion	Fosgate, Harold L.	Indianapolis	Marion
Feerer, Donald J.	Michigan City	La Porte	Foster, Lee N.	Indianapolis	Marion
Fein, Harry S.	LaPorte	LaPorte	Foster, Ray T.	New Castle	Henry
Feldman, Max	South Bend	St. Joseph	Fountaine, Thomas J.	Bedford	Lawrence
Fender, A. H.	Worthington	Greene	Fouts, Paul J.	Indianapolis	Marion
Fenneman, Robert J.	Evansville	Vanderburgh	Fowler, Richard R.	Bloomington	Owen-Monroe



Name	City	County	Name	City	County
Fox, C. Philip	Washington	Daviess-Martin	Garner, W. Stanley	Indianapolis	Marion
Fox, Maurice S.	Vincennes	Knox	Garner, Wm. H.	New Albany	Floyd
Fox, R. H. (S)	Bicknell	Knox	Garrett, John D. (S)	Indianapolis	Marion
Foy, H. W.	Fort Wayne	Allen	Garrett, Robert A.	Indianapolis	Marion
Frank, J. R.	Valparaiso	Porter	Garrison, James L.	Cumberland	Marion
Frank, L. L.	South Bend	St. Joseph	Garrison, Leon J.	Gas City	Grant
Franklin, Philip	Gary	Lake	Garton, H. W.	Ft. Wayne	Allen
Franklin, William L.	Indianapolis	Marion	Gaskill, Herbert S.	Indianapolis	Marion
Frankowski, Clementine	Whiting	Lake	Gastineau, David C.	Indianapolis	Marion
Frantz, Mount E.	Danville	Hendricks	Gastineau, F. M.	Indianapolis	Marion
Frasch, M. G.	Lafayette	Tippecanoe	Gatch, W. D.	Indianapolis	Marion
Frash, De Von W.	South Bend	St. Joseph	Gates, George E.	South Bend	St. Joseph
Frazin, Bernard	Indianapolis	Marion	Gaul, L. Edward	Evansville	Vanderburgh
Freed, Carl A.	Attica	Fountain-Warren	Gaunt, Everett W.	Alexandria	Madison
Freed, James C.	Attica	Fountain-Warren	Geckler, Charles E.	Muncie	Delaware-Blackford
Freed, John E., Sr.	Terre Haute	Vigo	Gehres, R. W.	Shelbyville	Shelby
Freed, John E., Jr.	Terre Haute	Vigo	Geick, Raymond	Fort Branch	Gibson
Freeman, F. M.	Goshen	Elkhart	Geider, Roy A.	Indianapolis	Marion
French, Wm. G.	Evansville	Vanderburgh	Geiger, Dillon	Bloomington	Owen-Monroe
Frey, Harley B.	Lafayette	Tippecanoe	Geisinger, L. N. (S)	Auburn	De Kalb
Frey, William B.	South Bend	St. Joseph	Geller, Samuel	Owensville	Gibson
Friedman, David K.	Indianapolis	Marion	Genovese, Pasquale	Indianapolis	Marion
Friedman, Isadore E.	Hammond	Lake	Gentile, John P.	New Albany	Floyd
Friedman, Morris S.	South Bend	St. Joseph	George, Charles L.	Indianapolis	Marion
Friedrich, Louis M. (S)	Hobart	Lake	Gerding, William J.	Fort Wayne	Allen
Frith, Gladys D.	South Bend	St. Joseph	Gerrish, D. A.	Terre Haute	Vigo
Frith, Louis G.	South Bend	St. Joseph	Gerrish, W. D.	Clinton	Parke-Vermillion
Fritsch, L. E.	Evansville	Vanderburgh	Gery, Richard E.	Lafayette	Tippecanoe
Fromhold, Willis A.	Indianapolis	Marion	Gessler, W. F.	Fort Wayne	Allen
Frost, Robert J.	Michigan City	LaPorte	Gevirtz, M. B.	Hammond	Lake
Fruth, Rodney B.	Connersville	Fayette-Franklin	Gibbs, Charles (S)	Greenfield	Hancock
Fruth, Virgil T.	Connersville	Fayette-Franklin	Gibbs, Joseph W.	Martinsville	Morgan
Fry, Robert D.	Indianapolis	Marion	Gibson, Greta	Indianapolis	Marion
Frybarger, S. S.	Converse	Miami	Gick, Herman	Indianapolis	Marion
Fullerton, R. L.	Indianapolis	Marion	Gifford, F. E.	Indianapolis	Marion
Funk, John W.	Muncie	Delaware-Blackford	Gilbert, Ivan	Terre Haute	Vigo
Funkhouser, A. G.	Indianapolis	Marion	Gilkison, John S.	Shoals	Daviess-Martin
Funkhouser, Elmer	Indianapolis	Marion	Gilkison, William L. (S)	Shoals	Daviess-Martin
Furgason, Paul C.	Indianapolis	Marion	Gill, Bernard P.	Evansville	Vanderburgh
Furniss, S. A. (S)	Indianapolis	Marion	Gill, Dee Dar	Greenfield	Hancock
Fuson, W. J.	Greencastle	Putnam	Gill, Thomas A.	Muncie	Delaware-Blackford
G			Gillespie, Chas. E. (S)	Seymour	Jackson
Gabe, Wm. E.	Indianapolis	Marion	Gillespie, Chas. F.	Indianapolis	Marion
Gaddy, Euclid T.	Indianapolis	Marion	Gillespie, Chauncey	Medaryville	Pulaski
Galante, Vincent J.	Chicago, Ill.	Lake	Gillespie, G. R.	Brownstown	Jackson
Galbreath, R. S.	Huntington	Huntington	Gillespie, J. E.	Indianapolis	Marion
Galbreath, J. P.	Burnettsville	White	Gillespie, J. F. (S)	Greencastle	Putnam
Galliher, Marjorie J.	Muncie	Delaware-Blackford	Gillette, Walter R.	Bluffton	Wells
Gallup, Palmer R.	Indianapolis	Marion	Gilliatt, J. P.	Salem	Washington
Gambill, Wm. D.	Indianapolis	Marion	Gillum, John R.	Terre Haute	Vigo
Gammieri, Robert L.	Indianapolis	Marion	Gilman, M. M.	South Bend	St. Joseph
Gannon, G. W.	Gary	Lake	Gilmore, Louis (S)	Vincennes	Knox
Ganser, Richard A.	Mishawaka	St. Joseph	Gilmore, R. A.	Michigan City	LaPorte
Gante, H. W.	Anderson	Madison	Gilmore, Robert W.	Michigan City	LaPorte
Ganz, Max	Marion	Grant	Gingerick, Chas. M.	Liberty Center	Wells
Garber, E. C.	Dunkirk	Jay	Ginsberg, Stewart	Marion	Grant
Garber, J. Neill	Indianapolis	Marion	Giordano, A. S.	South Bend	St. Joseph
Garber, Paul A.	South Whitley	Whitley	Girod, Arthur H.	Decatur	Adams
Garceau, George J.	Indianapolis	Marion	Gish, Howard M.	Brookston	White
Gard, Daniel A.	Indianapolis	Marion	Gitlin, Max M.	Bluffton	Wells
Gardiner, H. Glenn	East Chicago	Lake	Gitlin, Wm. A.	Bluffton	Wells
Gardiner, Sprague H.	Indianapolis	Marion	Givner, David	Indianapolis	Marion
Gardner, Buckman	Indianapolis	Marion	Glackman, J. C., Jr.	Rockport	Spencer
Gardner, M. D.	Michigan City	LaPorte	Glackman, J. C., Sr.	Rochester	Fulton
Gardner, Russell A.	Michigan City	LaPorte	Gladstone, N. H.	Fort Wayne	Allen
Garfield, M. D.	Indianapolis	Marion	Glass, R. L.	Indianapolis	Marion
Garland, Edgar	Evansville	Vanderburgh	Glendening, J. L.	Indianapolis	Marion
Garling, L. C.	Muncie	Delaware-Blackford	Glendening, Richard L.	Tell City	Perry
Garner, William (S)	Indianapolis	Marion	Glenn, Fred C.	Ramsey	Harrison-Crawford
			Glenn, L. F. (S)		
			Glock, H. E.	Fort Wayne	Allen





Name	City	County	Name	City	County
Harding, M. Richard	Indianapolis	Marion	Hays, George R.	Richmond	Wayne-Union
Harding, Myron S.	Indianapolis	Marion			
Hardtke, Eldred F.	Bloomington	Owen-Monroe	Hazinski, R. T.	Griffith	Lake
Hardy, John J.	North Liberty	St. Joseph	Headley, L. M.	Lebanon	Boone
Hare, Daniel M.	Evansville	Vanderburgh	Heard, Albert	Evansville	Vanderburgh
Hare, E. H.	Indianapolis	Marion	Heck, Martin C.	Jasper	Dubois
Hare, John H.	Evansville	Vanderburgh	Heck, Rolfe A.	College Corner, Ohio	Wayne-Union
Hare, Laura	Indianapolis	Marion			
Harger, Robert W.	Washington, D.C.	Marion	Hedde, E. L.	Logansport	Cass
Harkcom, H. E.	St. Paul	Decatur	Hedcock, R. A.	Frankfort	Clinton
Harkness, R. G.	Terre Haute	Vigo	Hedrick, James T.	Gary	Lake
Harlan, William	Ligonier	Noble	Hedrick, Philip W.	Indianapolis	Marion
Harless, Clarence M.	Chesterton	Porter	Hefti, Karl R.	Evansville	Vanderburgh
Harmon, C. J.	Richmond	Wayne-Union	Heilman, W. C.	New Castle	Henry
			Heinrich, Weston A.	Evansville	Vanderburgh
Harmon, Gladys H.	Richmond	Wayne-Union	Heinz, Dorothy C. V.	Indianapolis	Marion
			Held, George A.	Jasper	Dubois
Harmon, Vachelle E.	South Bend	St. Joseph	Heller, N. L.	Dunkirk	Jay
Harmon, Wayne	Lynn	Randolph	Helmen, H. W.	South Bend	St. Joseph
Harold, A. H. (S)	Indianapolis	Marion	Helmer, John F.	South Bend	St. Joseph
Harold N. E. (S)	Indianapolis	Marion	Henderson, Arvin	Ridgeville	Randolph
Harris, Albert J.	Michigan City	LaPorte	Henderson, Francis G.	Indianapolis	Marion
Harris, Carl B.	Indianapolis	Marion	Henderson, N. C.	Michigan City	LaPorte
Harris, Paul N.	Indianapolis	Marion	Henderson, R. A.	Muncie	Delaware-Blackford
Harris, R. F.	Noblesville	Hamilton			
Harris, Wm. Lee	Evansville	Vanderburgh	Hendricks, John D. (S)	Indianapolis	Marion
Harrison, B. L.	New Castle	Henry	Hendricks, John W.	Indianapolis	Marion
Harshman, L. P.	Ft. Wayne	Allen	Hendrix, Claude	Waveland	Montgomery
Harshman, Martin L.	Lafayette	Tippecanoe	Henley, Glenn (S)	Fairmount	Grant
Harstad, Casper	Rockville	Parke-Vermillion	Henn, R. Anthony	Greenfield	Hancock
			Hennessee, Philip C.	Indianapolis	Marion
Hart, L. Paul	University City, Mo.	Vanderburgh	Henning, Carl	Hanover	Jefferson-Switzerland
Hart, Robert B.	Columbus	Bartholomew-Brown	Henry, Alvin L.	Columbus	Bartholomew-Brown
Hart, Wm. D.	Anderson	Madison	Henry, Howard J.	Knox	Starke
Harter, Eli Blair	Lafayette	Tippecanoe	Henry, Russell S.	Indianapolis	Marion
Hartley, C. A., Jr.	Evansville	Vanderburgh	Hensler, B. M.	Anderson	Madison
Hartman, John	Angola	Steuben	Hepburn, C. K.	Indianapolis	Marion
Hartz, F. Minton	Evansville	Vanderburgh	Hepner, H. S.	Bloomington	Owen-Monroe
Harvey, Harry C.	Ft. Wayne	Allen			
Harvey, R. J.	Zionsville	Boone	Herd, Cloyn R.	Peru	Miami
Harvey, Verne K.	Alexandria, Va.	Marion	Herendeen, E. V.	Rochester	Fulton
			Heritier, C. Jules	Columbia City	Whitley
Hasewinkle, A. M.	Ft. Wayne	Allen	Herr, John W.	Mt. Vernon	Posey
Hasewinkel, Carroll	Indianapolis	Marion	Herrick, C. L.	Akron	Fulton
Hash, John S.	Noblesville	Hamilton	Herring, G. N.	Richmond	Wayne-Union
Hasl, Robert F.	Gary	Lake	Herrmann, Gordon T.	Evansville	Vanderburgh
Haslem, Ezra R.	Terre Haute	Vigo	Herrold, G. W.	Lafayette	Tippecanoe
Haslem, John R.	Terre Haute	Vigo	Hershey, E. A.	Churubusco	Whitley
Hasler, Norman B.	Crown Point	Lake	Herzer, C. C.	Evansville	Vanderburgh
Haslinger, C. J.	Indianapolis	Marion	Hess, Paul P.	New Albany	Floyd
Hastings, Warren C.	Ft. Wayne	Allen	Hetherington, A. M.	Indianapolis	Marion
Hatfield, B. F.	Indianapolis	Marion	Hetherington, John A.	Indianapolis	Marion
Hatfield, Jack J.	Indianapolis	Marion	Hetman, Mitchell J.	Westville	LaPorte
Hatfield, N. W.	Indianapolis	Marion	Heubi, John E.	Indianapolis	Marion
Hathaway, Clayton B.	Butler	DeKalb	Hewitt, M. I.	South Bend	St. Joseph
Hattendorf, A. P.	Ft. Wayne	Allen	Hiatt, R. L.	Ft. Wayne	Allen
Haugseth, Ellsworth K.	South Bend	St. Joseph	Hibner, Nolan A.	Monticello	White
Hauss, Augustus P.	New Albany	Floyd	Hickman, A. Lee	Hammond	Lake
Havens, Oscar	Cicero	Hamilton	Hickman, Walter	Indianapolis	Marion
Havens, R. E.	Ft. Wayne	Allen	Hicks, Joseph (S)	Arcadia	Hamilton
Havice, Jay F.	Miami Beach, Fla.	Allen	Hiestand, H. J.	Pennville	Jay
			Higgins, James L.	Petersburg	Pike
Hawes, J. K. (S)	Columbus	Bartholomew-Brown	Higgins, John R.	New Albany	Floyd
			High, Ralph L.	Muncie	Delaware-Blackford
Hawes, M. E.	Columbus	Bartholomew-Brown			
			Hilbert, John W.	South Bend	St. Joseph
Hawk, James H.	Indianapolis	Marion	Hildebrand, W. O. (S)	Topeka	LaGrange
Hayes, Jess D.	East Chicago	Lake	Hill, H. D.	Richmond	Wayne-Union
Hayes, T. R.	Muncie	Delaware-Blackford			
			Hill, H. E.	Muncie	Delaware-Blackford
Haymond, George N.	Warsaw	Kosciusko			
Haymond, Joseph L.	Indianapolis	Marion	Hill, Kenneth G.	New Castle	Henry
Hays, Everett L.	Indianapolis	Marion	Hill, Paul G.	Cambridge City	Wayne-Union

Name	City	County	Name	City	County
Hill, Robert	Muncie	Delaware-Blackford	Hostetter, Irwin S.	Muncie	Delaware-Blackford
Hill, T. N.	Scottsburg	Scott	Houser, D. Stanley	Lakeville	St. Joseph
Hilldrup, Don G.	Indianapolis	Marion	Houser, Wayne W.	Monon	White
Hillenbrand, Charles	Michigan City	LaPorte	Houseworth, John H.	Indianapolis	Marion
Hillery, John L.	Warsaw	Kosciusko	Houston, Fred D.	Lawrenceburg	Dearborn-Ohio
Hillis, L. J.	Logansport	Cass	How, John T. (S)	Lakeville	St. Joseph
Hillman, Marion W.	South Bend	St. Joseph	How, Louis E.	South Bend	St. Joseph
Hillman, W. H. (S)	South Bend	St. Joseph	Howard, W. H.	Hammond	Lake
Himebaugh, Gilbert	Veedsburg	Fountain-Warren	Howe, Fordyce L.	Ft. Wayne	Allen
Himebaugh, J. R. S.	Indianapolis	Marion	Howell, Joseph D.	Indianapolis	Marion
Himler, James M.	Indianapolis	Marion	Howell, R. D.	Indianapolis	Marion
Hinchman, C. P.	Geneva	Adams	Hoyt, Lester H.	Indianapolis	Marion
Hinchman, Jean F.	Parker	Randolph	Huber, Carl P.	Indianapolis	Marion
Hine, U. B.	Indianapolis	Marion	Huckleberry, Carl D.	Cloverdale	Putnam
Hines, A. V.	Auburn	DeKalb	Huckleberry, Irvin	Salem	Washington
Hines, Don C.	Indianapolis	Marion	Hudson, Foster J.	Indianapolis	Marion
Hippensteel, Harland	Auburn	DeKalb	Huff, A. D.	Marion	Grant
Hippensteele, Ralph	Fremont	Steuben	Huffman, A. D.	Acton	Marion
Hisrich, L. W.	Batesville	Ripley	Huffman, V. P.	South Whitley	Whitley
Hobbs, Arthur	Evansville	Vanderburgh	Hughes, Richard R.	Lafayette	Tippecanoe
Hochhalter, Marian	Logansport	Cass	Hughes, W. F. (S)	Indianapolis	Marion
Hodges, Fletcher	Indianapolis	Marion	Huggins, Victor S.	Evansville	Vanderburgh
Hodges, Wm. A.	Oaktown	Knox	Hull, A. W.	Elkhart	Elkhart
Hodgin, Phillip	Orleans	Orange	Hull, James E.	Indianapolis	Marion
Hodurski, Zigfield	Gary	Lake	Hull, Ronald H.	Portsmouth, Va.	Marion
Hoeger, H. R.	Connersville	Fayette-Franklin	Hummel, R. M.	Marion	Grant
Hoffman, A. F.	Ft. Wayne	Allen	Hummons, Henry L.	Indianapolis	Marion
Hoffman, Curtis R.	Richmond	Wayne-Union	Humphrey, Paul E.	Terre Haute	Vigo
Hoffman, Doris	Vincennes	Knox	Humphreys, Joe E.	Vincennes	Knox
Hoffman, Herman	Indianapolis	Marion	Humphreys, John W.	Crawfordsville	Montgomery
Hoffman, R. V.	South Bend	St. Joseph	Hunsberger, W. G.	Lafayette	Tippecanoe
Hoffmann, S. P., Sr.	Ft. Wayne	Allen	Hunt, Edgar J.	Terre Haute	Vigo
Hofmann, Andrew	Hammond	Lake	Hunt, Gayle J.	Richmond	Wayne-Union
Hofmann, J. Wm.	Indianapolis	Marion	Hunter, Donn	Greenfield	Hancock
Hogle, Frank D.	Logansport	Cass	Hunter, F. P.	Lafayette	Tippecanoe
Holdeman, Lillian	South Bend	St. Joseph	Hunter, Lowell G.	Milan	Ripley
Holdeman, R. W.	South Bend	St. Joseph	Huoni, J. S.	Jeffersonville	Clark
Holladay, L. J.	Lafayette	Tippecanoe	Hurley, Anson	Muncie	Delaware-Blackford
Holland, Chas. E.	Bloomington	Owen-Monroe	Hurley, John R.	Daleville	Delaware-Blackford
Holland, D. J.	Bloomington	Owen-Monroe	Hurt, L. B.	Indianapolis	Marion
Holland, Philip	Bloomington	Owen-Monroe	Huse, William M.	Indianapolis	Marion
Hollingsworth, A. A.	Indianapolis	Marion	Husted, Robert	Hammond	Lake
Hollingsworth, Marshall P. (S)	Princeton	Gibson	Hutchison, Donald R.	Fountain City	Wayne-Union
Hollis, Walter H.	Ft. Branch	Gibson	Hutto, W. H.	Kokomo	Howard
Holloway, W. A. (S)	Logansport	Cass	Hyatt, Gilbert T.	Evansville	Vanderburgh
Holman, J. E., Sr.	Indianapolis	Marion	Hyde, Carroll	South Bend	St. Joseph
Holman, J. E., Jr.	Indianapolis	Marion	I		
Holmes, Claude D.	Indianapolis	Marion	Iddings, J. W.	Crown Point	Lake
Holmes, Claude D., Sr.	Frankfort	Clinton	Ikns, R. G.	Lafayette	Tippecanoe
Holmes, G. W.	Gary	Lake	Imhof, Joseph D.	Muncie	Delaware-Blackford
Holmes, W. W.	Logansport	Cass	Ingwell, Guy B.	Knox	Starke
Holsinger, R. E.	Indianapolis	Marion	Inlow, Herbert	Shelbyville	Shelby
Holtzman, Paul W.	Indianapolis	Marion	Inlow, W. D.	Shelbyville	Shelby
Honan, Paul R.	Lebanon	Boone	Irey, P. R.	Plymouth	Marshall
Hood, Ainslee A.	Indianapolis	Marion	Irish, Wilbur J.	East Chicago	Lake
Hooke, Sam W.	Noblesville	Hamilton	Irwin, Glenn W., Jr.	Indianapolis	Marion
Hoopes, Jane	Evansville	Vanderburgh	Irwin, Seth	Anderson	Madison
Hoover, D. A.	Terre Haute	Vigo	Iske, Paul G.	Indianapolis	Marion
Hoover, J. J.	Terre Haute	Vigo	Isler, N. C.	Jeffersonville	Clark
Hoover, Peter B.	Boonville	Warrick	Iterman, G. E.	New Castle	Henry
Hopkins, J. R.	Hammond	Lake	Ives, R. J.	Francesville	Pulaski
Hopkins, Lester H.	Versailles	Ripley	J		
Hoppenrath, Wesley M.	Elwood	Madison	Jackson, Charles E.	Bluffton	Wells
Hoppenrath, Wm. (S)	Elwood	Madison	Jackson, Dean B.	Hartford City	Delaware-Blackford
Horst, William N.	Crown Point	Lake	Jackson, F. E.	Indianapolis	Marion
Horswell, R. G.	Bristol	Elkhart	Jackson, James W.	Indianapolis	Marion
Horwitz, Thomas	Indianapolis	Marion	Jackson, John F.	Fort Wayne	Allen
Horton, George R.	Ft. Wayne	Allen			
Hostetler, Carl M.	Goshen	Elkhart			



Name	City	County	Name	City	County
Jackson, J. K.	Aurora	Dearborn-Ohio	Jordan, Leo E.	Lynn	Randolph
Jackson, Jesse L.	Indianapolis	Marion	Joseph, Rex M.	Indianapolis	Marion
Jacobs, H. A.	Indianapolis	Marion	Jurgensen, Walter T.	Ft. Wayne	Allen
Jaeger, A. S. (S)	Indianapolis	Marion	Justin, Jerome W.	Hammond	Lake
Jahns, Albin A.	Chicago, Ill.	Lake	<b>K</b>		
James, N. A.	Tell City	Perry	Kabel, Robert N.	Terre Haute	Vigo
James, Thomas, Jr.	Huntington	Huntington	Kahan, H. L.	Gary	Lake
Jannasch, Maurice C.	Gary	Lake	Kahler, M. V.	Indianapolis	Marion
Jaquith, O. S. (S)	Indianapolis	Marion	Kahn, Alexander J.	Indianapolis	Marion
Jarrett, Paul E.	Anderson	Madison	Kahn, Howard L.	Indianapolis	Marion
Jay, Arthur N.	Indianapolis	Marion	Kalb, Everett L.	Indianapolis	Marion
Jeffries, K. I.	Indianapolis	Marion	Kaler, James	Plymouth	Marshall
Jenkins, Robert E.	Indianapolis	Marion	Kamm, Bernard A.	South Bend	St. Joseph
Jennings, Frank	Indianapolis	Marion	Kamman, G. H. (S)	Seymour	Jackson
Jewell, Earl B.	Logansport	Cass	Kammen, Leo	Indianapolis	Marion
Jewell, George M.	Kokomo	Howard	Kammen, Robert	Indianapolis	Marion
Jewett, Joe H.	Indianapolis	Marion	Kammer, Grace C.	Muncie	Delaware-Blackford
Jewett, Laurence (S)	Indianapolis	Marion			
Jewett, Robert E.	Indianapolis	Marion	Kammer, Walter F.	Muncie	Delaware-Blackford
Jinks, C. H.	Indianapolis	Marion			
Jinnings, Loren E.	Garrett	DeKalb	Kantzer, Floyd B.	Garrett	De Kalb
Jobes, James E.	Indianapolis	Marion	Kaplan, Benjamin B.	East Chicago	Lake
Jobes, N. E. (S)	Indianapolis	Marion	Karberg, Richard J.	Lafayette	Tippecanoe
Joest, Charles O.	Mishawaka	St. Joseph	Karn, John W.	South Bend	St. Joseph
Johantgen, Harold N.	Indianapolis	Marion	Karol, Herbert J.	Fort Wayne	Allen
Johns, D. R.	East Chicago	Lake	Karpel, Bernard	Mooresville	Morgan
Johns, Elmer	Zionsville	Boone	Karsell, W. A.	Bloomington	Owen-Monroe
Johns, N. C.	South Bend	St. Joseph			
Johnson, C. E.	Rensselaer	Jasper-Newton	Katterjohn, James C.	Indianapolis	Marion
		Fountain-Warren	Kauffman, Harley M.	Evansville	Vanderburgh
Johnson, Earl E.	Covington	Warren	Kauffman, Nelson N.	Indianapolis	Marion
		Montgomery	Kauffman, Sidney A.	Indianapolis	Marion
Johnson, F. D.	Waynetown	Vanderburgh	Kay, Oran	Spencer	Owen-Monroe
Johnson, G. C. (S)	Evansville	Vanderburgh			
Johnson, George M.	Richmond	Wayne-Union	Keck, Carleton A.	Fort Wayne	Allen
Johnson, Herbert S.	Lafayette	Tippecanoe	Keeling, F. E.	Portland	Jay
Johnson, James B.	Greencastle	Putnam	Keeling, J. E. (S)	Waldron	Shelby
Johnson, J. J. (S)	Milltown	Harrison-Crawford	Keenan, R. L.	Indianapolis	Marion
		Harrison-Crawford	Keever, C. H.	Indianapolis	Marion
Johnson, J. M.	Palmyra	Harrison-Crawford	Keezer, William S.	Vincennes	Knox
		Lake	Keiser, V. D.	Indianapolis	Marion
Johnson, Lonnie B.	Gary	Tippecanoe	Keith, F. E. (S)	St. Bernice	Parke-Vermillion
Johnson, Lowell R.	Lafayette	Tippecanoe			
Johnson, M. H. C.	Vincennes	Knox	Keller, Frank (S)	Alexandria	Madison
Johnson, Owen	Peru	Miami	Kelley, Clement E.	Indianapolis	Marion
Johnson, Paul S.	Richmond	Wayne-Union	Kelly, Don E.	Indianapolis	Marion
		Rush	Kelly, Frank	Argos	Marshall
Johnson, R. B.	Rushville	Rush	Kelly, J. F.	Indianapolis	Marion
Johnson, S. L.	Evansville	Vanderburgh	Kelly, J. N. (S)	LaPorte	La Porte
Johnson, Thomas W.	Indianapolis	Marion	Kelly, W. C.	Anderson	Madison
Johnson, W. A.	Perrysville	Parke-Vermillion	Kelly, W. R.	Goshen	Elkhart
		Marion	Kelly, Walter F. (S)	Indianapolis	Marion
Johnson, Wm. F.	Indianapolis	Marion	Kelly, William M.	Indianapolis	Marion
Johnston, Alan	Plainfield	Hendricks	Kelsey, L. E.	Kewanna	Fulton
Johnston, Richard M.	Fort Wayne	Allen	Kelsey, Robert M.	LaPorte	La Porte
Johnston, Robert L.	Bluffton	Wells	Kemp, John T.	Michigan City	La Porte
Johnston, R. G.	Huntington	Huntington	Kemp, W. A.	Connersville	Fayette-Franklin
Jolly, Lewis E.	Madison	Jefferson-Switzerland			
		Spencer	Kemper, A. T. (S)	Muncie	Delaware-Blackford
Jolly, W. P.	Richland	Spencer			
Jones, Albert T.	Anderson	Madison	Kempf, G. F.	Indianapolis	Marion
Jones, Allen W.	Indianapolis	Marion	Kendall, F. M.	Nappanee	Elkhart
Jones, Charles A.	Franklin	Johnson	Kendrick, Frank J.	Gary	Lake
Jones, Clifford M.	Whiting	Lake	Kendrick, W. M.	Indianapolis	Marion
Jones, D. D. (S)	Berne	Adams	Kennedy, Eva	Camden	Carroll
Jones, David	Lafayette	Tippecanoe	Kennedy, Hall	Indianapolis	Marion
Jones, David E.	Indianapolis	Marion	Kennedy, H. F.	Indianapolis	Marion
Jones, E. S.	Hammond	Lake	Kennedy, R. O.	Rushville	Rush
Jones, Francis P.	Indianapolis	Marion	Kennedy, W. U.	New Castle	Henry
Jones, George	Wanamaker	Marion	Kenoyer, Wilbur L.	Indianapolis	Marion
Jones, H. E.	Anderson	Madison	Kent, J. A.	Mulberry	Clinton
Jones, John C.	LaPorte	LaPorte	Kent, Richard N.	Ft. Wayne	Allen
Jones, John Carl	Logansport	Cass	Kenyon, C. E.	Cambridge	Wayne-Union
Jones, King Solomon	Michigan City	LaPorte			
Jones, R. B.	LaPorte	LaPorte	Kephart, S. Bruce	Bluffton	Wells
Jones, W. W.	Frankfort	Clinton	Kepler, R. W.	La Porte	La Porte

Name	City	County	Name	City	County
Kercheval, John M.	Clinton	Parke-Vermillion	Kohlstaedt, Karl C.	Indianapolis	Marion
Kern, C. B. (S)	Muncie	Delaware-Blackford	Kohlstaedt, K. G.	Indianapolis	Marion
Kern, C. G.	Lebanon	Boone	Kohne, C. J.	Decatur	Adams
Kerr, Donald M.	Bedford	Lawrence	Kohrman, Benj. M.	Michigan City	La Porte
Kerr, Harry R.	Indianapolis	Marion	Kolanko, Leon A.	Hammond	Lake
Kerrigan, R. L.	Michigan City	La Porte	Kolettis, George J.	Gary	Lake
Kerrigan, William F.	Rockport	Spencer	Komoroske, J. E.	East Chicago	Lake
Keseric, Nicholas E.	French Lick	Orange	Koons, Karl M.	Indianapolis	Marion
Kessler, Robert B.	Evansville	Vanderburgh	Koontz, William A.	Gas City	Grant
Ketcham, Jane M.	Indianapolis	Marion	Kopanko, Bernard F.	Huntington, W. Va.	Lake
Ketcham, John S.	Rossville	Clinton	Kopcha, Joseph E.	Gary	Lake
Kidd, James G.	Roann	Wabash	Kopecky, Robert R.	Indianapolis	Marion
Kidder, J. J. (S)	Salamonia	Jay	Kopp, Herschel S.	Santa Barbara, Calif.	Marion
Kidder, Orva T.	Ft. Wayne	Allen	Kopp, O. A.	Anderson	Madison
Kiechle, Frederick L.	Evansville	Vanderburgh	Koransky, David S.	Hammond	Lake
Kilgore, Byron, Jr.	Indianapolis	Marion	Korn, Jerome M.	Gary	Lake
Killian, E. Camille	Logansport	Cass	Kornafel, L. H.	Indianapolis	Marion
Killian, Edgar W.	Logansport	Cass	Kraft, Bennett	Indianapolis	Marion
Kim, Young D.	Beech Grove	Marion	Kraft, Haldon C.	Noblesville	Hamilton
Kimbrough, Robert F.	Fort Wayne	Allen	Kramer, A. A.	South Bend	St. Joseph
Kime, Charles E.	Richmond	Wayne-Union	Kraning, Kenneth	Kewanna	Fulton
Kime, E. N.	Indianapolis	Marion	Kratz, Paul E.	Columbia City	Whitley
Kime, J. T. (S)	Petersburg	Pike	Kratzer, E. F. (S)	Kokomo	Howard
Kindell, H. D.	New Richmond	Montgomery	Kresler, Leon	Rensselaer	Jasper-Newton
King, Dale	Fairmount	Grant	Kress, James W.	Michigan City	LaPorte
King, Everett A.	Honolulu, T.H.	Vanderburgh	Kretsch, R. W.	Hammond	Lake
King, James R.	Silver Lake	Kosciusko	Krieble, Wm. W.	Terre Haute	Vigo
King, Joseph W.	Anderson	Madison	Krieger, George M.	Michigan City	La Porte
King, P. C.	Swayzee	Grant	Kron, R. Vincent	East Gary	Lake
King, Robert W.	Cedar Lake	Lake	Krueger, Frederick W.	Richmond	Wayne-Union
King, William E.	Indianapolis	Marion	Krueger, John E.	South Bend	St. Joseph
King, William F. (S)	Indianapolis	Marion	Kruse, E. H.	Fort Wayne	Allen
Kingsbury, J. K.	Indianapolis	Marion	Kruse, Walter E.	Fort Wayne	Allen
Kinnaman, H. A.	Crawfordsville	Montgomery	Kubik, Francis J.	Michigan City	La Porte
Kinneman, R. E.	Greenfield	Hancock	Kublely, James D.	Plymouth	Marshall
Kintner, Burton E.	Elkhart	Elkhart	Kudele, L. T.	Whiting	Lake
Kinzel, Robert J. W.	Indianapolis	Marion	Kuder, Howard V.	Muncie	Delaware-Blackford
Kinzie, M. Dale	Goshen	Elkhart	Kuhn, Frederick L.	South Bend	St. Joseph
Kirch, L. N.	Norton, Va.	Vanderburgh	Kuhn, Hedwig S.	Hammond	Lake
Kirkhoff, Paul J.	Indianapolis	Marion	Kuhn, Hugh A.	Hammond	Lake
Kirklin, Oren L.	Indianapolis	Marion	Kuhn, R. W.	Wilkinson	Hancock
Kirshman, F. E.	Muncie	Delaware-Blackford	Kunkler, Joseph	Terre Haute	Vigo
Kirtley, J. M.	Crawfordsville	Montgomery	Kunkler, Wm. C.	Terre Haute	Vigo
Kirtley, William R.	Indianapolis	Marion	Kuntz, Herman W.	Indianapolis	Marion
Kiser, E. F.	Indianapolis	Marion	Kurtz, Fred B.	Indianapolis	Marion
Kissinger, Charles C.	Fort Wayne	Marion	Kurtz, Philip L.	Indianapolis	Marion
Kissinger, K. L.	Angola	Steuben	Kurtz, William A.	Tipton	Tipton
Kistler, James J.	La Porte	La Porte	Kwitny, I. J.	Indianapolis	Marion
Kistner, Arthur W.	Elkhart	Elkhart		L	
Kitterman, Harry E.	Indianapolis	Marion	LaBier, C. Russell	Terre Haute	Vigo
Klahr, Elsworth	Indianapolis	Marion	LaBier, Clarence R. (S)	Terre Haute	Vigo
Klain, B. V.	Indianapolis	Marion	Ladig, Donald S.	Fort Wayne	Allen
Klamer, Charles H.	Jasper	Dubois	LaDine, C. B.	Indianapolis	Marion
Klatch, Ben Z.	Lafayette	Tippecanoe	LaDuron, Jules F.	Muncie	Delaware-Blackford
Klaus, J. M.	Crown Point	Lake	LaFollette, Forrest R.	Whiting	Lake
Kleifgen, William A.	Fort Wayne	Allen	LaFollette, Robert E.	New Albany	Floyd
Kleindorfer, R. L.	Evansville	Vanderburgh	Laird, L. A.	Richmond	Wayne-Union
Kleinman, F. J.	Hebron	Porter	Lamb, E. B.	Indianapolis	Marion
Klepinger, H. E.	Lafayette	Tippecanoe	Lamb, Russell	Indianapolis	Marion
Kling, Victor F.	Michigan City	La Porte	Lamber, C. K.	Indianapolis	Marion
Klingler, Maurice O.	Plymouth	Marshall	Lamey, James L.	Anderson	Madison
Knapp, Arthur L.	South Bend	St. Joseph	Lamey, P. T.	Anderson	Madison
Kneidel, John H.	Frankfort	Clinton	Lancet, Robert O.	Terre Haute	Vigo
Knepple, L. R. (S)	Kokomo	Howard	Lane, W. H. (S)	Angola	Steuben
Knode, Kenneth T.	South Bend	St. Joseph	Lane, Wm. H.	South Bend	St. Joseph
Knotts, Slater	Rochester	Fulton	Lang, Joseph E.	South Bend	St. Joseph
Knowles, Charles Y.	Indianapolis	Marion	Lang, Shirley C.	Evansville	Vanderburgh
Knowles, Robert P.	Indianapolis	Marion	Langdon, H. K. (S)	Indianapolis	Marion
Ko, Richard	Eaton	Delaware-Blackford	Langdon, J. Ray	Indianapolis	Marion
Kobrak, H. G.	Chicago, Ill.	Lake	Langenbahn, C. J.	South Bend	St. Joseph
Kobrin, Meyer W.	Gary	Lake	Langohr, John	Columbia City	Whitley
Koch, Elmer L.	Danville	Hendricks	Langsdon, Fred	Gaston	Delaware-Blackford
Koehler, Elmer G.	Elkhart	Elkhart			
Kohlstaedt, George	Indianapolis	Marion			



Name	City	County	Name	City	County
Lansford, John	Redkey	Jay	Lipsey, Alfred J.	Hammond	Lake
Laramore, Ward	Indianapolis	Marion	Liss, Emanuel C.	South Bend	St. Joseph
Larkin, Bernard J.	Indianapolis	Marion	Little, John W. (S)	Indianapolis	Marion
Larmore, J. L.	Anderson	Madison	Little, Wm. J.	Indianapolis	Marion
Larmore, Sarah H.	Anderson	Madison	Littlefield, Paul A.	San Francisco, Calif.	Marion
LaRocca, Joseph	Valparaiso	Porter			
Larrabee, James F.	Hammond	Lake	Litzenberger, S. W.	Anderson	Madison
Larrison, G. D.	Morocco	Jasper-Newton	Lloyd, Claude A.	Washington	Daviess-Martin
Larson, G. O.	La Porte	La Porte	Lloyd, Robert P.	Fort Wayne	Allen
Larson, John A.	Logansport	Cass	Lochry, R. L.	Indianapolis	Marion
LaSalle, R. M.	Wabash	Wabash	Lockhart, Jack M.	Connersville	Fayette-Franklin
Lashley, Donald L.	Tell City	Perry			
Laubscher, Clarence	Evansville	Vanderburgh	Lockhart, Philip B.	South Bend	St. Joseph
Laudeman, W. A.	Elwood	Madison	Loehr, W. M.	Indianapolis	Marion
Lauer, D. B.	Dana	Parke-Vermillion	Loewenstein, W. L.	Terre Haute	Vigo
			Logan, A. R. (S)	Petersburg	Pike
Lautz, Herbert A.	Hammond	Lake	Logan, F. W.	Mishawaka	St. Joseph
Lava, Irving M.	Michigan City	La Porte	Logan, James Z.	Richmond	Wayne-Union
Lavengood, R. W.	Marion	Grant	Logan, Jesse R.	Evansville	Vanderburgh
Lawler, George F.	Indianapolis	Marion	Logan, Richard S.	Elkhart	Elkhart
Lawrence, Edwin A.	Indianapolis	Marion	Lohman, Robert M.	Fort Wayne	Allen
Lawrence, Joseph C.	Evansville	Vanderburgh	Lohoff, Lewis C.	Tell City	Perry
Laws, H. J.	Lafayette	Tippecanoe	Lomax, Claude	Costa Mesa, Calif.	Marion
Laws, Kenneth F.	Lafayette	Tippecanoe			
Lawson, I. H.	Kendallville	Noble	Long, Max	Marion	Grant
Lazo, Vicente R.	Hammond	Lake	Long, Paul L.	Anderson	Madison
Leak, Robert H.	Boswell	Benton	Long, William H.	Indianapolis	Marion
Leasure, J. K.	Indianapolis	Marion	Loomis, Charles H.	Richmond	Wayne-Union
Leatherman, H. L.	Indianapolis	Marion	Loomis, N. S.	Indianapolis	Marion
Lebioda, Henry S.	Gary	Lake	Loop, Floyd A. (S)	Lafayette	Tippecanoe
Lee, Glen Ward	Richmond	Wayne-Union	Loop, Frederick A.	Lafayette	Tippecanoe
Leedy, Gladys J.	Indianapolis	Marion	Lord, G. C.	Indianapolis	Marion
Leff, Abe	Indianapolis	Marion	Lorenty, T. B.	Gary	Lake
Leffel, James M.	Indianapolis	Marion	Loudermilk, J. L.	Ft. Wayne	Allen
Leffler, William T.	Indianapolis	Marion	Love, George N.	Indianapolis	Marion
Lefforge, E. Everett	Veedersburg	Fountain-Warren	Love, John R.	Terre Haute	Vigo
			Lovell, Martin H.	Gary	Lake
Lehman, Harold	Berne	Adams	Lovett, H. D.	Whitestown	Boone
Lehman, Kenneth M.	Topeka	LaGrange	Loving, J. B.	New Goshen	Vigo
Lehmborg, O. F.	Columbia City	Whitley	Luckett, Coen L.	Terre Haute	Vigo
Lehner, John H.	Fort Wayne	Allen	Luckey, H. A.	Wolf Lake	Noble
Leich, Charles F.	Evansville	Vanderburgh	Luckey, R. C.	Wolf Lake	Noble
Leming, Ben L.	Ft. Wayne	Allen	Ludwick, Harry	South Bend	St. Joseph
Lemon, Herbert K.	Logansport	Cass	Ludwig, Oscar D.	Indianapolis	Marion
Lenk, George G.	Fort Wayne	Allen	Luginbill, Howard M.	South Bend	St. Joseph
Leonard, Henry S. (S)	Indianapolis	Marion	Lukemeyer, Geo. T.	Jasper	Dubois
Leser, R. U.	Indianapolis	Marion	Lukemeyer, St. John	Jasper	Dubois
Leslie, Ernil	Evansville	Vanderburgh	Lukemeyer, L. C. (S)	Huntingburg	Dubois
Lett, Emory B.	Loogootee	Daviess-Martin	Lukemeyer, L. C. (S)	Indianapolis	Marion
			Lundenbill, Emery D.	Indianapolis	Lake
Levering, Guy P. (S)	Lafayette	Tippecanoe	Lundeberg, Ralph A.	Griffith	Elkhart
Levi, Leon	Indianapolis	Marion	Lundt, Milo O.	Elkhart	Howard
Levin, Eli	East Chicago	Lake	Lung, B. D.	Kokomo	Marion
Levin, Ralph T.	Indianapolis	Marion	Lurie, Paul R.	Indianapolis	Marion
Lewis, George N.	Gary	Lake	Lutes, D. L.	Wheatland	Knox
Lewis, James F.	Liberty	Wayne-Union	Luthy, Karl R.	South Bend	St. Joseph
Lewis, Marvin A.	Chicago, Ill.	Lake	Lutz, Georgianna	Gary	Lake
Lewis, Robert J.	Lawrence	Marion	Luzadder, J. E. (S)	Bloomington	Owen-Monroe
Libbert, Edwin L.	Indianapolis	Marion			
Lichtenberg, Melvin	Indianapolis	Marion	Luzadder, J. E., Jr.	New Carlisle	St. Joseph
Lidikay, Edward C.	Indianapolis	Marion	Lybrook, D. E.	Young	Cass
Life, Homer	New Castle	Henry		America	
Lindenberg, Paul G.	Indianapolis	Marion	Lybrook, William B.	Indianapolis	Marion
Lindsay, H. B.	Washington	Daviess-Martin	Lynch, Harold D.	Evansville	Vanderburgh
			Lynch, Otis R.	Marengo	Harrison-Crawford
Line, H. E.	Chili	Miami			
Ling, John F.	Richmond	Wayne-Union	Lynch, Paul	Evansville	Vanderburgh
Lingeman, Byron N.	Crawfordsville	Montgomery	Lynn, F. M. (S)	Peru	Miami
Lingeman, Raleigh E.	Indianapolis	Marion	Lyon, Florence	Portland	Jay
Lingeman, Roger	Indianapolis	Marion	Lyons, R. E., Jr.	Bloomington	Owen-Monroe
Link, Goethe	Indianapolis	Marion			
Linn, E. E.	La Porte	La Porte		M	
Linton, C. D.	Indianapolis	Marion	MacDonald, J. A. (S)	Interlaken, N.Y.	Marion
Linton, C. E. (S)	Medaryville	Pulaski			
Lionberger, John R.	South Bend	St. Joseph	MacDonnell, Thomas M.	Marshfield, Mo.	Marion
Lippoldt, Charles L.	Batesville	Ripley	MacKenzie, Pierce	Evansville	Vanderburgh

Name	City	County	Name	City	County
MacLeod, Donald F.	Morocco	Jasper-Newton	Mather, J. W.	East Gary	Lake
Macer, Clarence G.	Evansville	Vanderburgh	Mathews, W. C.	Kentland	Jasper-
Machledt, J. H.	Whiteland	Johnson			Newton
Mackel, Frederick O.	Ft. Wayne	Allen	Mathys, Alfred	Mauckport	Harrison-
Mackey, Harry S.	Indianapolis	Marion			Crawford
Mackey, John E.	Indianapolis	Marion	Matthew, John R.	North Judson	Starke
Macy, George W.	Columbus	Bartholomew-	Matthew, W. B.	Indianapolis	Marion
		Brown	Matthews, B. J.	Indianapolis	Marion
Mader, John H.	Richmond	Wayne-Union	Matthews, Chas. B. (S)	Hammond	Lake
Madtson, A. Ricks	Indianapolis	Marion	Matthews, D. W.	North Vernon	Jennings
Magennis, H. L.	Indianapolis	Marion	Matthews, William M.	Indianapolis	Marion
Mahoney, Charles L.	Terre Haute	Vigo	Mattox, Don M.	Terre Haute	Vigo
Mahuron, Boyd L.	Dayton, Ohio	Delaware-	Matychowiak, Francis	Knightstown	Henry
		Blackford	Maurer, J. F.	Brazil	Clay
Majsterek, S. L.	Gary	Lake	Maurer, Robert M.	Brazil	Clay
Makovsky, Theodore	Valparaiso	Porter	Maxon, Roy V.	Lapel	Madison
Malcolm, Russell	Richmond	Wayne-Union	Maxwell, J. B. (S)	Logansport	Cass
Malmstone, F. A. (S)	Griffith	Lake	May, George A.	Madison	Jefferson-
Malone, L. A.	Terre Haute	Vigo			Switzerland
Malott, Fred	Converse	Miami	May, R. Milton.	Gary	Lake
Malouf, S. D.	Peru	Miami	Mayer, Robert	Indianapolis	Marion
Manalan, Maurice M.	Indianapolis	Marion	Mayfield, C. H. (S)	Reynolds	White
Manifold, Harold M.	Fortville	Hancock	McAdams, Hugh B.	Lafayette	Tippecanoe
Manion, Marlow W.	Indianapolis	Marion	McArdle, Edward G.	Ft. Wayne	Allen
Manley, Chas. N.	Rising Sun	Dearborn-	McArt, Bruce A.	Indianapolis	Marion
		Ohio	McBride, James S.	Indianapolis	Marion
Mann, Mortimer	Indianapolis	Marion	McBride, Noel S.	Terre Haute	Vigo
Manning, George	Fort Wayne	Allen	McCabe, Theodore E.	Ft. Wayne	Allen
Manning, Joseph C.	Indianapolis	Marion	McCallister, John W.	Ft. Wayne	Allen
Manning, K. R.	Indianapolis	Marion	McCallum, J. T. C.	Indianapolis	Marion
Manuel, Donald	Edinburg	Johnson	McCarthy, Daniel J. (S)	Indianapolis	Marion
Manzie, Michael	Lyons	Greene	McCarthy, Jeremiah A.	Whiting	Lake
Maple, J. B.	Sullivan	Sullivan	McCartney, Donald H.	Indianapolis	Marion
Marchand, Austin F.	Haubstadt	Gibson	McCarty, Virgil	Princeton	Gibson
Marchand, Edwin V.	Haubstadt	Gibson	McCaskey, C. H.	Indianapolis	Marion
Marchant, Clarence H.	Bloomington	Owen-Monroe	McClain Edwin S.	Indianapolis	Marion
Marcus, Emanuel	Hammond	Lake	McClain, Marvin	Scottsburg	Scott
Marcus, M. C.	Gary	Lake	McClellan, John B.	Muncie	Delaware-
Maris, Lee J.	Attica	Fountain-			Blackford
		Warren	McClelland, D. C.	Lafayette	Tippecanoe
Markel, I. J.	Elkhart	Elkhart	McClintock, James A.	Muncie	Delaware-
Markey, R. J. P.	Hammond	Lake			Blackford
Markle, Joseph G.	Hammond	Lake	McClure, Clark	Knox	Starke
Marks, H. H.	Huntington	Huntington	McClure, S. E.	Monon	White
Marks, Maurice I.	Indianapolis	Marion	McConnell, Wm. C.	Sunman	Ripley
Marks, Ora L.	East Chicago	Lake	McCool, J. H.	Evansville	Vanderburgh
Marks, Salvo P.	Hammond	Lake	McCool, W. E. (S)	Evansville	Vanderburgh
Marr, Griffith	Columbus	Bartholomew-	McCord, C. B.	Veedsburg	Fountain-
		Brown			Warren
Marsh, Chester A.	Hagerstown	Henry	McCormick, C. O., Jr.	Indianapolis	Marion
Marsh, George W.	Lafayette	Tippecanoe	McCormick, C. O., Sr.	Indianapolis	Marion
Marshall, Albert L., Jr.	Indianapolis	Marion	McCormick, H. D.	Vincennes	Knox
Marshall, C. R.	Indianapolis	Marion	McCormick, W. C.	Terre Haute	Vigo
Marshall, George L.	Bourbon	Marshall	McCown, P. E.	Indianapolis	Marion
Marshall, Lloyd C.	Mt. Summit	Henry	McCoy, George E.	Muncie	Delaware-
Marshall, Millard R.	Gary	Lake			Blackford
Martin, C. E.	Lynn	Randolph	McCoy, Roy R.	Ft. Wayne	Allen
Martin, Charles F.	Mishawaka	St. Joseph	McCracken, J. O.	Montgomery	Daviess-
Martin, Floyd S.	Goshen	Elkhart			Martin
Martin, Frank D.	Bedford	Lawrence	McCraley, William J.	South Bend	St. Joseph
Martin, Guy	Seymour	Jackson	McCullough, J. Y.	New Albany	Floyd
Martin, Hugh E.	Indianapolis	Marion	McDaniel, F. P.	Atlanta	Hamilton
Martin, Loren H.	Indianapolis	Marion	McDevitt, D. R.	Indianapolis	Marion
Martin, W. B.	La Porte	La Porte	McDonald, Frank C.	New Castle	Henry
Martz, Bill L.	Indianapolis	Marion	McDonald, J. D.	University	Vanderburgh
Martz, Carl D.	Indianapolis	Marion		City, Mo.	
Marvel, Robert J.	Indianapolis	Marion	McDonald, R. M.	South Bend	St. Joseph
Maschmeyer, R. H.	Shoals	Daviess-	McDonald, V. G.	Anderson	Madison
		Martin	McDowell, Fletcher W.	Muncie	Delaware-
Mason, Bernard	South Bend	St. Joseph			Blackford
Mason, Donald G.	Angola	Steuben	McDowell, George A.	Ft. Wayne	Allen
Mason, Everett E.	Evansville	Vanderburgh	McDowell, M. M.	Vincennes	Knox
Mason, Harold	Winona Lake	Kosciusko	McEachern, Cecil	Ft. Wayne	Allen
Mason, Lester M.	Terre Haute	Vigo	McElroy, J. S.	New Castle	Henry
Mason, Richard L.	Hammond	Lake	McElroy, R. S.	Princeton	Gibson
Masters, John M.	Indianapolis	Marion	McEwen, J. W.	Terre Haute	Vigo
Masters, R. J.	Indianapolis	Marion	McFadden, James M.	Lafayette	Tippecanoe
Mather, Robert	W. Lafayette	Tippecanoe	McFall, J. R. S.	Ft. Wayne	Allen



Name	City	County	Name	City	County
McFarland, Corley B.	South Bend	St. Joseph	Meyer, Milo G.	Michigan City	La Porte
McGrath, Michael F.	Indianapolis	Marion	Meyer, Orlando L.	Bedford	Lawrence
McGuff, Paul	Indianapolis	Marion	Meyer, R. C.	Vincennes	Knox
McGuire, D. F.	East Chicago	Lake	Meyer, Theodore O.	Ft. Wayne	Allen
McIlroy, Richard J.	Claypool	Kosciusko	Meyn, Werner P.	Terre Haute	Vigo
McIlwain, Eleanor	Marion	Grant	Michaelis, S. C.	Ft. Wayne	Allen
McIlwain, Robert	Marion	Grant	Michaels, Joseph F. (S)	Edinburg	Johnson
McIndoo, R. E.	Kokomo	Howard	Micheli, A. J.	Indianapolis	Marion
McIntire, Clarence R.	Indianapolis	Marion	Middleton, H. N.	Indianapolis	Marion
McIntosh, Wilbert (H)	Riley	Vigo	Middleton, Thomas O.	Bloomington	Owen-Monroe
McIntyre, Charles J.	Indianapolis	Marion	Mikesch, W. H.	South Bend	St. Joseph
McIntyre, J. M.	Indianapolis	Marion	Miklozek, John E.	Terre Haute	Vigo
McKay, Robert	LaFontaine	Wabash	Miley, Weir M.	Anderson	Madison
McKechnie, Franklin B.	Indianapolis	Marion	Miller, Carl G.	Ft. Wayne	Allen
McKee, C. E. (S)	Dublin	Wayne-Union	Miller, Charles A. (S)	Princeton	Gibson
McKee, Horace N. (S)	Elkhart	Elkhart	Miller, D. B. (S)	Terre Haute	Vigo
McKee, H. S.	Greensburg	Decatur	Miller, E. H.	Valparaiso	Porter
McKeeman, D. H.	Ft. Wayne	Allen	Miller, Frank	Morristown	Shelby
McKeeman, L. S.	Ft. Wayne	Allen	Miller, Galen R.	Elkhart	Elkhart
McKenna, H. J.	South Bend	St. Joseph	Miller, H. Allison	Marion	Grant
McKinley, A. D.	Indianapolis	Marion	Miller, H. L. (S)	West Baden	Orange
McKinley, Joseph	Lafayette	Tippecanoe	Miller, Harold E.	Seymour	Jackson
McKinney, D. H.	Lafayette	Tippecanoe	Miller, H. Paul	Ft. Wayne	Allen
McKittrick, Jack	Washington	Daviess-	Miller, Hugh A.	Elkhart	Elkhart
		Martin	Miller, J. Don	Indianapolis	Marion
McLaughlin, C. P.	Pendleton	Madison	Miller, James C.	Greensburg	Decatur
McLaughlin, G. C.	Terre Haute	Vigo	Miller, John R.	Indianapolis	Marion
McLaughlin, James R.	Flora	Carroll	Miller, Joseph A.	Cumberland	Marion
McLean, James S.	Hammond	Lake	Miller, LaVerne B.	Evansville	Vanderburgh
McLelland, Mary R.	Bloomington	Owen-Monroe	Miller, M. E.	Goshen	Elkhart
McMahan, Virgil	Vincennes	Knox	Miller, Mahlon F.	Ft. Wayne	Allen
McMichael, F. J.	Gary	Lake	Miller, Mary E.	Bloomington	Owen-Monroe
McMichael, R. M.	Muncie	Delaware-	Miller, Milton	Evansville	Vanderburgh
		Blackford	Miller, Milo	South Bend	St. Joseph
McMillan, F. G.	Indianapolis	Marion	Miller, Minor	Evansville	Vanderburgh
McNabb, G. B.	Carthage	Rush	Miller, Orval J.	Ft. Wayne	Allen
McNairy, Donald J.	Ft. Wayne	Allen	Miller, R. S.	Indianapolis	Marion
McNamara, John P.	Indianapolis	Marion	Miller, Ray D.	Martinsville	Morgan
McNaughton, L. M.	Washington	Daviess-	Miller, Richard C.	Shelbyville	Shelby
		Martin	Miller, Richard H.	Ft. Wayne	Allen
McNeely, M. J.	Dillsboro	Dearborn-	Miller, Robert J.	Evansville	Vanderburgh
		Ohio	Miller, Roland E.	Lafayette	Tippecanoe
McQuiston, R. J.	Indianapolis	Marion	Miller, S. J.	W. Lafayette	Tippecanoe
McTurnan, Robert W.	Indianapolis	Marion	Miller, S. T.	Elkhart	Elkhart
McVaugh, Charles C.	Chicago, Ill.	Madison	Miller, Virgil	Akron	Fulton
McVey, Clarence A.	Hammond	Lake	Miller, Wallace	Indianapolis	Marion
McWilliams, W. B.	Liberty	Wayne-Union	Miller, Wm. A.	Hagerstown	Henry
Mead, C. H.	Bluffton	Wells	Miller, Wm. J.	Rochester,	Allen
Meade, Walter W.	Bicknell	Knox		Minn.	
Medcalf, Norman L.	Lamar	Spencer	Millikan, William	Indianapolis	Marion
Megenhardt, D. S.	Indianapolis	Marion	Mills, Fred E.	Evansville	Vanderburgh
Mehl, Rudolph A.	Evansville	Vanderburgh	Mills, J. F.	Wabash	Wabash
Meikle, Louise J.	W. Lafayette	Tippecanoe	Minczewski, Richard C.	Gary	Lake
Meiks, Lyman T.	Indianapolis	Marion	Mininger, Edward P.	Elkhart	Elkhart
Meiner, J. A.	Kokomo	Howard	Mino, Raymond W.	Evansville	Vanderburgh
Meiser, Robert	Huntington	Huntington	Mino, Victor H.	Evansville	Vanderburgh
Meister, Doris	Anderson	Madison	Mintz, Alfred M.	Indianapolis	Marion
Melloh, A. F.	Indianapolis	Marion	Mirro, John A.	Lowell	Lake
Mendenhall, Clarence D.	Indianapolis	Marion	Misch, William	Cedar Lake	Lake
Mendenhall, Edgar	Ft. Wayne	Allen	Mishkin, Irving	Elkhart	Elkhart
Mendez, Carlos	Elkhart	Elkhart	Mitchell, Albert M.	Terre Haute	Vigo
Mentendiek, M. H.	Indianapolis	Marion	Mitchell, E. T.	Romney	Tippecanoe
Mercer, Samuel R.	Ft. Wayne	Allen	Mitchell, Earl H.	Indianapolis	Marion
Merchant, Raymond	Crown Point	Lake	Mitchell, Edward O.	Indianapolis	Marion
Meredith, E. J.	Richmond	Wayne-Union	Mitchell, G. L.	Smithville	Owen-Monroe
Mericle, Earl W.	Indianapolis	Marion	Mitchell, George S.	Bluffton	Wells
Merrell, B. M.	Rockville	Parke-	Mitchell, R. E.	Springfield,	Marion
		Vermillion		Missouri	
Merrell, Paul	Indianapolis	Marion	Mitman, F. B.	Huntington	Huntington
Mertz, H. O.	Indianapolis	Marion	Moats, C. F.	Ft. Wayne	Allen
Mertz, John H. O.	Indianapolis	Marion	Moats, G. E.	Ft. Wayne	Allen
Messer, F. W.	Kendallville	Noble	Modisett, Jackson W.	Madison	Jefferson-
Metcalf, George B.	Anderson	Madison			Switzerland
Metcalfe, G. E.	South Bend	St. Joseph	Modisett, Marcella S.	Madison	Jefferson-
Mettler, Don C.	Denver, Colo.	De Kalb			Switzerland
Meyer, Herman A.	Ft. Wayne	Allen	Modjeska, Gerald S.	Indianapolis	Marion
Meyer, K. T.	Evansville	Vanderburgh	Modjeski, Joseph R.	Hammond	Lake
			Modjeski, Raymond J.	Hammond	Lake

Name	City	County	Name	City	County
Moehlenkamp, C. E.	Evansville	Vanderburgh	Mull, P. L. (S)	Louisville, Ky.	Washington
Moenning, W. P.	Indianapolis	Marion	Muller, Lullus P.	Indianapolis	Marion
Mohr, Ann L. M.	West Terre Haute	Vigo	Muller, Paul F.	Indianapolis	Marion
Molenda, Robert V.	Michigan City	LaPorte	Mullikin, C. W.	Greensburg	Decatur
Molengraft, C. J.	Gary	Lake	Mumford, E. B.	Indianapolis	Marion
Molloy, W. J. (S)	Muncie	Delaware-Blackford	Munk, C. E.	Kendallville	Noble
Molt, W. F. (S)	Indianapolis	Marion	Murdock, H. L.	Ft. Wayne	Allen
Monroe, F. Bruce	Crown Point	Lake	Murphy, E. C.	South Bend	St. Joseph
Montgomery, J. R.	Owensville	Gibson	Murphy, E. W.	New Albany	Floyd
Montgomery, L. G.	Muncie	Delaware-Blackford	Murphy, Edward U.	Evansville	Vanderburgh
Montgomery, S. B. (S)	Cynthiana	Posey	Murphy, Harry	Franklin	Johnson
Montgomery, Wm. F.	Indianapolis	Marion	Murphy, Joseph F., Jr.	Hammond	Lake
Moon, Charles E.	Centerpoint	Clay	Murphy, Josephine	South Bend	St. Joseph
Moore, B. B.	Indianapolis	Marion	Murphy, M. G.	Morgantown	Morgan
Moore, Edwin G.	Gary	Lake	Murray, Ernest C.	Kokomo	Howard
Moore, E. Gregory	Gary	Lake	Murray, Jas. S., Jr.	Beverly Hills, Calif.	Marion
Moore, H. T.	Indianapolis	Marion	Musacchio, Frederick A.	Hammond	Lake
Moore, R. G.	Vincennes	Knox	Musselman, G. G.	Terre Haute	Vigo
Moore, Robert M.	Indianapolis	Marion	Myers, Charles W.	Indianapolis	Marion
Moore, Thomas C.	Indianapolis	Delaware-Blackford	Myers, Paul W.	Fresno, Calif.	Marion
Moore, W. C.	Muncie	Delaware-Blackford	Myers, R. V.	Indianapolis	Marion
Moosey, Louis	Union Mills	LaPorte	Myers, Wm. C.	Dana	Parke-Vermillion
Moran, Mark M.	Portland	Jay		N	
Moran, Noel D.	Versailles	Ripley	Nafe, C. A.	Indianapolis	Marion
Moravec, Arthur E.	Ft. Wayne	Allen	Nagan, Robert F.	Indianapolis	Marion
Morchan, Samuel	Indianapolis	Marion	Nahrwold, Elmer W.	Ft. Wayne	Allen
Morec, George J.	Indianapolis	Marion	Nakadate, Katsumi J.	Hammond	Lake
Morford, Guy	Owensboro, Ky.	Howard	Nance, W. K.	Vincennes	Knox
Morgan, Margaret E.	Indianapolis	Marion	Napper, Floyd	Scottsburg	Scott
Morgan, S. P.	LaPorte	LaPorte	Nash, Charles B.	Valparaiso	Porter
Moriarty, John R.	Indianapolis	Marion	Nash, Justin R.	Albion	Noble
Morr, J. W. (S)	Albion	Noble	Nason, R. A.	Garrett	DeKalb
Morrical, Russell J.	Logansport	Cass	Nassef, George	Walkerton	St. Joseph
Morris, Hyman	Gary	Lake	Nave, H. E.	Fountaintown	Shelby
Morris, J. W.	Muncie	Delaware-Blackford	Navin, Hugh K.	Fortville	Hancock
Morris, Robert A.	Anderson	Madison	Nay, E. O.	Terre Haute	Vigo
Morris, Warren V.	Monticello	White	Nay, Richard M.	Indianapolis	Marion
Morris, W. F. (S)	Princeton	Gibson	Neal, Leonard W.	Hammond	Marion
Morrison, John S. (S)	Lafayette	Tippecanoe	Neale, Alfred E.	Anderson	Madison
Morrison, J. T.	Greensburg	Decatur	Need, Louis T.	Indianapolis	Marion
Morrison, Lindsey (S)	Hammond	Lake	Neely, A. S.	New Middletown	Harrison-Crawford
Morrison, Lewis E. II	Indianapolis	Marion	Neidballa, E. G.	Bristol	Elkhart
Morrison, W. R.	Kokomo	Howard	Neier, O. C. (S)	Indianapolis	Marion
Morrow, George W.	Logansport	Cass	Neifert, Noel	Tell City	Perry
Mortenson, L. J.	Ft. Wayne	Allen	Nelson, Carl A.	West Lebanon	Fountain-Warren
Morton, Walter P.	Indianapolis	Marion	Nelson, F. Dale	South Bend	St. Joseph
Moser, E. B.	Windfall	Tipton	Nelson, Harold E.	Muncie	Delaware-Blackford
Moser, Edward (S)	Woodburn	Allen	Nelson, Paul Leon	Anderson	Madison
Moser, R. H.	Indianapolis	Marion	Nelson, R. B.	Hammond	Lake
Moses, George E.	Worthington	Greene	Nelson, Raymond	South Bend	St. Joseph
Moses, Robert E.	Worthington	Greene	Nelson, Walfred A.	Gary	Lake
Moss, Bobby L.	Indianapolis	Marion	Nenneker, Henry (S)	Evansville	Vanderburgh
Moss, Harlan B.	Indianapolis	Marion	Nesbit, L. L.	Anderson	Madison
Moss, Herschel C.	Indianapolis	Marion	Nester, Henry G.	Indianapolis	Marion
Moss, M. J.	Yorktown	Delaware-Blackford	Netherton, C. R.	Chalmers	White
Moswin, Jack A.	Gary	Lake	Neucks, Howard C.	Evansville	Vanderburgh
Mothersill, M. H.	Indianapolis	Marion	Neudorff, Louis G.	Terre Haute	Vigo
Mott, C. A.	South Bend	St. Joseph	Neukamp, Frank H.	Connersville	Fayette-Franklin
Moulton, Lillian	Indianapolis	Marion	Neumann, K. O.	Lafayette	Tippecanoe
Mount, M. S.	Bloomfield	Greene	Neuwalt, Frank	Gary	Lake
Mount, Wm. M.	Crawfordsville	Montgomery	Newby, A. C.	Sheridan	Hamilton
Mountain, Francis	Connersville	Fayette-Franklin	Newby, Eugene	Sheridan	Hamilton
Mozingo, A. E.	Indianapolis	Marion	Newcomb, Wm. K.	Royal Center	Cass
Muelchi, Adeline F.	Evansville	Vanderburgh	Newcomber, Frank V.	Elwood	Madison
Mueller, Hilbert M.	South Bend	St. Joseph	Newland, A. E.	Bedford	Lawrence
Mueller, Lawrence W.	Ft. Wayne	Allen	Newman, A. E.	Evansville	Vanderburgh
Mueller, Lillian B.	Indianapolis	Marion	Nichols, Anne Sackett	Greencastle	Putnam
Muhleman, C. E.	LaPorte	LaPorte	Nichols, Wm. E. (S)	Hammond	Lake
			Nickel, Allen C.	Bluffton	Wells
			Nicosia, J. B.	East Chicago	Lake
			Nie, Grover	Huntington	Huntington



Name	City	County	Name	City	County
Nie, Louis W.	Indianapolis	Marion	Owens, Richard R.	Muncie	Delaware-Blackford
Niedermayer, Alfred	Evansville	Vanderburgh	Owens, Thomas R.	Muncie	Delaware-Blackford
Nielsen, Juul C.	Indianapolis	Marion	Owens, Tracy	Indianapolis	Marion
Nigh, R. M.	Fairland	Shelby	Owens, Walter Lee	Indianapolis	Marion
Nill, John H.	Ft. Wayne	Allen	Owsley, Charlotte M.	Hartford City	Delaware-Blackford
Nisenbaum, Harold	Evansville	Vanderburgh	Owsley, Guy A.	Hartford City	Delaware-Blackford
Nixon, Byron	Farmland	Randolph	Oyer, J. H.	Ft. Wayne	Allen
Noble, T. B., Jr.	Indianapolis	Marion		P	
Nodinger, Louis	Hammond	Lake	Pace, J. V.	New Albany	Floyd
Noe, Wm. R.	Bedford	Lawrence	Paff, W. A.	Elkhart	Elkhart
Nolt, E. V.	Columbia City	Whitley	Pahmeier, J. W.	Sandborn	Knox
Nolting, H. F.	Indianapolis	Marion	Paine, George E.	Elkhart	Elkhart
Nonte, Leo R.	Evansville	Vanderburgh	Painter, Donald S.	Ft. Wayne	Allen
Norman, Wm. H.	Indianapolis	Marion	Painter, L. W.	Winchester	Randolph
Norman, O. B.	Indianapolis	Marion	Palm, John M.	Brazil	Clay
Norris, Allen A. (S)	Elkhart	Elkhart	Palmer, Russell H.	Gary	Lake
Norris, Ernest B.	Middlebury	Elkhart	Panares, Solomon V.	Hammond	Lake
Norris, H. L.	Indianapolis	Marion	Pancost, Vernon K.	Elkhart	Elkhart
Norris, Max S.	Indianapolis	Marion	Pandolfo, Harry	Indianapolis	Marion
Norton, H. J.	Columbus	Bartholomew-Brown	Paris, D. W.	Kokomo	Howard
Norton, Horace	Washington	Daviess-Martin	Paris, J. M.	New Albany	Floyd
Norwick, Sydney	San Lorenzo, Calif.	Marion	Parke, D. Davis	South Bend	St. Joseph
Nourse, Myron H.	Indianapolis	Marion	Park, Byron J.	Richmond	Wayne-Union
Nugen, Harold	Auburn	DeKalb	Parker, Carl B.	Wingate	Montgomery
Nugent, Edwin J.	Indianapolis	Marion	Parker, C. B.	Ft. Wayne	Allen
Nutter, Wyndham H.	Rushville	Rush	Parker, G. F.	Greencastle	Putnam
	O		Parker, Geo. F., Jr.	Indianapolis	Marion
Oak, David	Hanna	LaPorte	Parker, H. C.	Gary	Lake
Oak, D. D.	La Crosse	LaPorte	Parker, J. F.	Indianapolis	Marion
Obery, George	Batesville	Ripley	Parker, Portia	Indianapolis	Marion
O'Brian, Earl J.	Indianapolis	Marion	Parks, George A.	Hartford City	Delaware-Blackford
O'Bryan, Richard B.	Columbus	Bartholomew-Brown			
Ochsner, Harold C.	Indianapolis	Marion	Parratt, Louis W.	Gary	Lake
Ockerman, Kenneth R.	Demotte	Jasper-Newton	Parrish, Richard K.	Decatur	Adams
O'Conner, James J.	Los Angeles, Calif.	Lake	Pastor, Julius W.	Evansville	Vanderburgh
O'Dell, Harry C.	Farmersburg	Sullivan	Patrick, G. B.	Elkhart	Elkhart
O'Dell, Thomas A.	Indianapolis	Marion	Patten, V. C. (S)	Morristown	Shelby
Olcott, C. W.	Aurora	Dearborn-Ohio	Patterson, Cecil L.	Charlestown	Clark
			Patterson, Wm. K.	Anderson	Madison
O'Leary, F. T.	Logansport	Cass	Patton, Martin T.	Indianapolis	Marion
Oliphant, F. W.	Mount Vernon	Posey	Paul, Wm. Thomas F.	Hammond	Lake
Oliphant, J. T.	Farmersburg	Sullivan	Paulissen, George T.	Indianapolis	Marion
Oliphant, R. W.	Terre Haute	Vigo	Pauszek, Thomas B.	South Bend	St. Joseph
Olney, Thomas A. (S)	South Bend	St. Joseph	Payne, Arthur C.	East Chicago	Lake
Olson, K. L.	South Bend	St. Joseph	Paynter, Morris B.	Southport	Marion
Olvey, Ottis N.	Indianapolis	Marion	Peacock, Norman F.	Crawfordsville	Montgomery
O'Malley, Martha	Indianapolis	Marion	Peacock, Robert	Muncie	Delaware-Blackford
Omstead, Milton	Petersburg	Pike			
Omstead, Trevalyn W.	Huntington	Huntington	Pearce, Roy V.	Terre Haute	Vigo
O'Neil, Martin J.	Rensselaer	Jasper-Newton	Pearlman, Samuel	Lafayette	Tippecanoe
			Pearson, John R. (S)	Bedford	Lawrence
Oppenheimer, Ernst	Evansville	Vanderburgh	Pearson, Lyman R.	Indianapolis	Marion
Orders, C. E.	Indianapolis	Marion	Pearson, William E.	Wabash	Wabash
Ornelas, Joseph P.	Gary	Lake	Pebworth, A. C. (S)	Indianapolis	Marion
O'Rourke, Carroll	Ft. Wayne	Allen	Peck, Franklin B.	Indianapolis	Marion
Orr, Wm. Robert	Mishawaka	St. Joseph	Peck, Edward A.	Hammond	Lake
Osborne, Harry S. (S)	Leesburg, Fla.	Marion	Peck, James F.	Princeton	Gibson
Osterman, Louis	Seymour	Jackson	Peiffer, Geraldine M.	Hammond	Lake
Oswald, Robert H.	Evansville	Vanderburgh	Peirce, James D.	Indianapolis	Marion
Oswalt, James T.	Mitchell	Lawrence	Peltier, Hubert C.	Indianapolis	Marion
Otten, Claude F.	Indianapolis	Marion	Pence, Benjamin F.	Columbia City	Whitley
Otten, Ralph E.	Darlington	Montgomery	Pennington, W. E.	Indianapolis	Marion
Ottinger, R. C.	Indianapolis	Marion	Permer, Erwin	Indianapolis	Marion
Overpeck, Charles	Greensburg	Decatur	Perrin, K. F.	Ft. Wayne	Allen
Overpeck, George H.	Alexandria	Madison	Perry, F. G.	Ft. Wayne	Allen
Overshiner, Lyman	Columbus	Bartholomew-Brown	Person, Theodore	Vevay	Jefferson-Switzerland
Owen, Abraham	Bloomington	Owen-Monroe	Peters, Elmer E.	Brookville	Fayette-Franklin
Owen, J. E.	Indianapolis	Marion	Peters, R. J. D.	Indianapolis	Marion
Owen, Margaret A.	Bloomington	Owen-Monroe	Peterson, Joel A.	Lafayette	Tippecanoe
			Petitjean, H. G.	Haubstadt	Gibson
			Petranoff, T. V.	Indianapolis	Marion

Name	City	County	Name	City	County
Petrass, Andrew	South Bend	St. Joseph	Present, Julian	Evansville	Vanderburgh
Petronella, S. J.	East Chicago	Lake	Price, Douglas W.	Nappanee	Elkhart
Pettijohn, F. L. (S)	Indianapolis	Marion	Price, Ernest H.	Danville	Hendricks
Petway, Allen P.	Madison	Jefferson-Switzerland	Price, Francis W.	Indianapolis	Marion
			Price, James O.	Indianapolis	Marion
Peyton, Frank W.	Lafayette	Tippecanoe	Price, Shirley G.	Evansville	Vanderburgh
Pfaff, Dudley	Indianapolis	Marion	Priebe, Fred H.	Hillsboro	Fountain-Warren
Pfaff, John A. (S)	Indianapolis	Marion			
Pfafflin, C. A. (S)	Indianapolis	Marion	Prosser, Wm. O. H.	Bloomington	Owen-Monroe
Pfeifer, James M.	Lawrenceburg	Dearborn-Ohio			
Pfrommer, John	Crane	Daviess-Martin	Proudfit, Charles H.	South Bend	St. Joseph
			Province, O. A.	Franklin	Johnson
Pfuetze, Max	Logansport	Cass	Province, William D.	Franklin	Johnson
Phares, Robert W.	Kokomo	Howard	Pryor, R. C.	Indianapolis	Marion
Phelps, Stephen R.	Indianapolis	Marion	Przednowek, A. C.	LaPorte	LaPorte
Phillips, John F.	Ft. Wayne	Allen	Pugh, Willis L.	Evansville	Vanderburgh
Phillips, William R.	Glenwood	Fayette-Franklin	Pulskamp, B. H.	Wolcottville	Noble
			Purcell, Jack H.	Boonville	Warrick
Phipps, Leland K.	Union City	Randolph	Purcell, Richard J.	Griffith	Lake
Piazza, Leonard F.	Michigan City	LaPorte	Puterbaugh, K. E.	Albany	Delaware-Blackford
Pickett, Robert D.	Indianapolis	Marion			
Pierce, Gene Stratton	New Albany	Floyd	Pyle, Harold D.	South Bend	St. Joseph
Pierce, H. J.	Terre Haute	Vigo			
Pierce, Wm. J.	Indianapolis	Marion			
Pierson, P. R.	New Albany	Floyd			
Pierson, Robert H.	Crawfordsville	Montgomery			
Pierson, Thomas A.	New Palestine	Hancock			
Pike, Warren H.	Hobart	Lake			
Pilcher, Jack	Indianapolis	Marion			
Pilecki, Peter J.	Michigan City	LaPorte			
Pilot, Jean	Hammond	Lake			
Pippenger, W. G.	Brook	Jasper-Newton			
Pirkle, H. B.	Rockville	Parke-Vermillion			
Pitkin, Edward M.	Martinsville	Morgan			
Pitkin, M. C.	Martinsville	Morgan			
Pizzo, Anthony	Bloomington	Owen-Monroe			
Plain, George	South Bend	St. Joseph			
Plank, C. Robert	Michigan City	LaPorte			
Plautz, Geraldine Z.	Indianapolis	Marion			
Ploughe,	Elwood	Madison			
Monroe L. (S)					
Ploughe, R. R.	Elwood	Madison			
Poda, George	Newport	Parke-Vermillion			
Polhemus, Gretchen I.	New Albany	Floyd			
Polhemus, Warren C.	Anderson	Madison			
Pollak, Lewis	Indianapolis	Marion			
Pollard, Walter	Evansville	Vanderburgh			
Pollom, Robert	Crawfordsville	Montgomery			
Pomeroy, Rex K.	Plymouth	Marshall			
Ponczek, Edward	Monroeville	Allen			
Pontius, Edwin E.	Alexandria, Va.	Marion			
Poolitson, Geo. C.	Bloomington	Owen-Monroe			
Popp, M. F.	Ft. Wayne	Allen			
Popplewell, Arvine G.	Indianapolis	Marion			
Porro, Francis W.	Evansville	Vanderburgh			
Porter, Carl M.	Jasonville	Greene			
Porter, Dale	Indianapolis	Marion			
Porter, E. A.	Westport	Decatur			
Porter, George C. (S)	Linton	Greene			
Porter, Jack	Lebanon	Boone			
Porter, M. F.	Ft. Wayne	Allen			
Portteus, Walter L.	Franklin	Johnson			
Possolt, T. R.	Elkhart	Elhart			
Poston, C. L.	New Castle	Henry			
Potter, Richard M.	Ridgeville	Randolph			
Potter, Thomas P., Jr.	South Bend	St. Joseph			
Powell, Edgar H.	Valparaiso	Porter			
Powell, J. Paxton	Marion	Grant			
Premuda, F. E.	Hammond	Lake			
Prenatt, Francis	Madison	Jefferson-Switzerland			
Prentiss, Nelson M.	Ft. Wayne	Allen			



Name	City	County	Name	City	County
Regan, George L.	Sellersburg	Clark	Robison, C. A.	Frankfort	Clinton
Reich, Clarence E.	Evansville	Vanderburgh	Robison, J. S.	Winchester	Randolph
Reid, Chas. A.	Indianapolis	Marion	Robrock, Lawrence M.	Michigan City	LaPorte
Reid, Robert W.	Union City	Randolph	Rockey, Noah A.	Ft. Wayne	Allen
Reilly, James F.	Vincennes	Knox	Rodenbeck, Frank	Arcadia	Hamilton
Reisler, Simon	Indianapolis	Marion	Rodin, Herman H.	South Bend	St. Joseph
Reitz, Thomas F.	Evansville	Vanderburgh	Rodriguez, Juan	Ft. Wayne	Allen
Remich, A. C.	Hammond	Lake	Roesch, Ryland	Warsaw	Kosciusko
Renbarger, L. L.	Marion	Grant	Rogers, Donald L.	Indianapolis	Marion
Rendel, D. T.	Hammond	Lake	Rogers, Evered E.	Auburn	DeKalb
Rendel, H. E.	Mexico	Miami	Rogers, O. F.	Bloomington	Owen-Monroe
Reppert, Roland L.	Decatur	Adams	Rogers, R. C. (S)	Bloomington	Owen-Monroe
Rettig, A. C.	Muncie	Delaware- Blackford	Rogers, Thomas P.	Philadelphia, Pa.	Marion
Reusser, Amos (S)	Berne	Adams	Rohn, Robert J.	Indianapolis	Marion
Reynolds, D. M. (S)	Garrett	DeKalb	Rohr, Joseph H.	Elkhart	Elkhart
Reynolds, J. S.	Gary	Lake	Rohrer, J. R.	Elnora	Daviess- Martin
Reynolds, R. P.	Garrett	DeKalb	Roller, C. W.	Indianapolis	Marion
Reynolds, Richard J.	Terre Haute	Vigo	Romberger, Floyd T.	W. Lafayette	Tippecanoe
Rhamy, A. P.	Wabash	Wabash	Romberger, Floyd T., Jr.	Indianapolis	Marion
Rhea, G. D.	Greencastle	Putnam	Rommel, Clarence H.	W. Lafayette	Tippecanoe
Rhea, James C.	Beech Grove	Marion	Roose, Lisle W.	Nappanee	Elkhart
Rhind, A. W.	Hammond	Lake	Ropp, Eldon R.	Oakland City	Gibson
Rhodes, A. H.	Princeton	Gibson	Ropp, H. E.	New Harmony	Posey
Rhodes, Theodore D.	Indianapolis	Marion	Rosenak, Bernard D.	Indianapolis	Marion
Rhorer, H. M.	Kokomo	Howard	Rosenbaum, David	Indianapolis	Marion
Rhorer, John G.	Marion	Grant	Rosenbaum, Irving, Jr.	Indianapolis	Marion
Rice, Raymond M.	Indianapolis	Marion	Rosenbaum, L. E.	Anderson	Madison
Rice, Thurman B.	Indianapolis	Marion	Rosenblatt, B. B.	Evansville	Vanderburgh
Rice, T. R. (S)	Petersburg	Pike	Rosenbloom, P. J.	Gary	Lake
Rice, W. B.	Ft. Wayne	Allen	Rosenfeld, Norman B.	Clinton	Parke- Vermillion
Richard, Norman F.	Shelbyville	Shelby	Rosenheimer, Geo. M.	South Bend	St. Joseph
Richards, D. H. (S)	Vincennes	Knox	Rosenthal, Carl	Hammond	Lake
Richards, E. E.	Russellville	Putnam	Rosenwasser, Jacob	Mishawaka	St. Joseph
Richardson, C. L.	Rochester	Fulton	Roser, A. J.	Ft. Wayne	Allen
Richardson, Thad T.	Indianapolis	Marion	Rosevear, Henry J.	Hammond	Lake
Richart, J. V.	Terre Haute	Vigo	Ross, Alexander T.	Indianapolis	Marion
Richer, O. H.	Warsaw	Kosciusko	Ross, Ben R.	Bloomington	Owen-Monroe
Richter, Arthur B.	Indianapolis	Marion	Ross, Guy E.	Anderson	Madison
Richter, John C.	LaPorte	LaPorte	Ross, Harry P.	Richmond	Wayne-Union
Richter, Samuel	New Orleans, La.	Lake	Ross, James S.	Richmond	Wayne-Union
Ricketts, J. W.	Indianapolis	Marion	Ross, W. W.	La Porte	La Porte
Ridgeway, O. W.	Indianapolis	Marion	Rossiter, D. L.	Ft. Wayne	Allen
Ridgway, Alton H.	Indianapolis	Marion	Rossow, Russell J.	Evansville	Vanderburgh
Rifner, E. S.	Van Buren	Grant	Roth, Bertram	Indianapolis	Marion
Rigg, J. F.	Indianapolis	Marion	Roth, James	Wolf Lake	Noble
Riggs, Floyd	Terre Haute	Vigo	Roth, Leo	Gary	Lake
Rigley, E. L.	South Bend	St. Joseph	Rothberg, Maurice J.	Ft. Wayne	Allen
Riley, Frank (S)	Jamestown	Boone	Rothberger, Daniel J.	Roswell, N.M.	Marion
Ringham, Jarrett	Evansville	Vanderburgh	Rothring, Howard E.	Columbus	Bartholomew- Brown
Rininger, Harold C.	Evansville	Vanderburgh	Rothrock, Philip W.	Lafayette	Tippecanoe
Rinker, Earl B.	Indianapolis	Marion	Rothschild, C. J.	Ft. Wayne	Allen
Rinne, John I.	Lapel	Madison	Rotman, Harry G.	Jasonville	Greene
Ripley, John W.	Seymour	Jackson	Rotman, Sam I.	Jasonville	Greene
Rissing, Walter J.	Ft. Wayne	Allen	Row, D. Hamilton	Indianapolis	Marion
Ritchey, Hardin	New Canaan, Conn.	Marion	Row, George S.	Osgood	Ripley
Ritchey, J. O.	Indianapolis	Marion	Row, Perrie Q.	Hammond	Lake
Ritchie, William D.	Evansville	Vanderburgh	Rowdabaugh, Marshall J.	Melrose Park, Ill.	St. Joseph
Ritterman, George W.	Columbus	Bartholomew- Brown	Rowe, Howard H.	Rochester	Fulton
Ritter, Wayne L.	Indianapolis	Marion	Royster, Robert A.	Evansville	Vanderburgh
Ritz, Albert S.	Evansville	Vanderburgh	Rozelle, Clarence V.	Anderson	Madison
Rivers, Glynn A.	Muncie	Delaware- Blackford	Rubens, Eli	South Bend	St. Joseph
Robb, John A.	Indianapolis	Marion	Rubin, Gerald S.	Indianapolis	Marion
Roberts, Floyd N.	Phoenix, Ariz.	Henry	Rubin, M. R.	Fresno, Calif.	Lake
Robertson, A. N.	New Albany	Floyd	Rubin, Milton M.	Terre Haute	Vigo
Robertson, D. W. (S)	Deputy	Jefferson- Switzerland	Rubin, Simon S.	Gary	Lake
Robertson, James S.	Plymouth	Marshall	Ruby, Fred McKemy	Union City	Randolph
Robertson, M. O.	Bedford	Lawrence	Ruddell, Karl R.	Indianapolis	Marion
Robertson, Ray	Indianapolis	Marion	Ruddell, Keith R.	Indianapolis	Marion
Robertson, W. C.	Chesterton	Porter	Ruddick, H. C.	Evansville	Vanderburgh
Robertson, William S.	Spiceland	Henry	Rudesill, C. L.	Indianapolis	Marion
Robinson, Earl U.	Evansville	Vanderburgh	Rudesill, Robert	Rochester, Minn.	Marion
Robinson, Walter K.	Gary	Lake			

Name	City	County	Name	City	County
Rudicel, Max	Kokomo	Howard	Schimmelpfennig, Robert W.	Kansas City, Mo.	Marion
Rudolph, Carl J.	South Bend	St. Joseph	Schirmer, Robert H.	Evansville	Vanderburgh
Rudolph, F. G.	Hammond	Lake	Schlademan, Karl R.	Ft. Wayne	Allen
Rudolph, Stephen, Jr.	Indianapolis	Marion	Schlagel, T. F., Jr.	Indianapolis	Marion
Rudser, D. H.	Whiting	Lake	Schlegel, Edward H.	Ft. Wayne	Allen
Runge, Paul W.	Richmond	Wayne-Union	Schlemmer, George H.	Warsaw	Kosciusko
Rupe, Lloyd O.	Elkhart	Elkhart	Schlesinger, Daniel	Pittsburgh, Pa.	Lake
Rupel, Ernest	Indianapolis	Marion	Schlesinger, Jacob	Hammond	Lake
Rusche, Henry J.	Evansville	Vanderburgh	Schlosser, H. C.	Elkhart	Elkhart
Ruschli, E. B.	Lafayette	Tippecanoe	Schmidt, Eugene F.	Ft. Wayne	Allen
Rusk, Hubert M.	Wallace	Fountain-Warren	Schmidt, Loren F.	Indianapolis	Marion
Russell, Richard H.	Evansville	Vanderburgh	Schmidt, Richard H.	Indianapolis	Marion
Rust, Byron K.	Indianapolis	Marion	Schmiedicke, P. H.	Williamsport	Fountain-Warren
Ruth, Martin L.	Indianapolis	Marion	Schmitt, Richard K.	Columbus	Bartholomew-Brown
Rutherford, C. W. (S)	Indianapolis	Marion	Schmoll, Robert J.	Ft. Wayne	Allen
Ryan, Glen V.	Indianapolis	Marion	Schneider, Carl J.	Indianapolis	Marion
Ryan, H. J.	Gary	Lake	Schneider, C. P.	Evansville	Vanderburgh
Ryan, William J.	Columbus	Bartholomew-Brown	Schneider, Kenneth	Nashville	Bartholomew-Brown
S			Schneider, Louis A.	Ft. Wayne	Allen
Sacks, Harry J.	Indianapolis	Marion	Schoen, Frederic L.	Ft. Wayne	Allen
Sage, Charles V., Jr.	Richmond	Wayne-Union	Schoolfield, Wm. E.	Orleans	Orange
Sage, Russell	Indianapolis	Marion	Schott, Edward J. (S)	Terre Haute	Vigo
Sagel, Jacob	Gary	Lake	Schreiner, John E.	Bremen	Marshall
Sahlman, Hans	Ft. Wayne	Allen	Schriefer, Victor V.	Evansville	Vanderburgh
Saint, William	New Castle	Henry	Schroeder, Henry	Washington	Daviess-Martin
Sala, J. J.	Gary	Lake	Schuchman, Abe	Indianapolis	Marion
Sala, Walter R.	Gary	Lake	Schuchman, Gabriel	Indianapolis	Marion
Salb, Leo A.	Jasper	Dubois	Schuldt, T. S.	Pierceton	Kosciusko
Salb, Max C.	Indianapolis	Marion	Schuler, R. P.	Kokomo	Howard
Sallee, William T.	Greensburg	Decatur	Schulfer, Richard J.	Hammond	Lake
Salon, Harry W.	Ft. Wayne	Allen	Schulhof, M. G.	Muncie	Delaware-Blackford
Salon, N. L.	Ft. Wayne	Allen	Schulze, Wm.	Vincennes	Knox
Salzman, Morris	Indianapolis	Marion	Schumaker, Robert A.	Terre Haute	Vigo
Samples, J. T. (S)	Boonville	Warrick	Schuman, Edith B.	Bloomington	Owen-Monroe
Sanders, Harry M.	Indianapolis	Marion	Schuster, Dwight W.	Indianapolis	Marion
Sanders, J. A.	Auburn	De Kalb	Schutt, J. B.	Ligonier	Noble
Sanderson, R. B.	South Bend	St. Joseph	Schwartz, Fred C.	Kokomo	Howard
Sandock, Isadore	South Bend	St. Joseph	Schwartz, W. D. (S)	Portland	Jay
Sandorf, M. H.	Indianapolis	Marion	Scoins, W. H.	Ft. Wayne	Allen
Sandoz, Harry	South Bend	St. Joseph	Scott, Frank M.	South Bend	St. Joseph
Sandoz, Louis A.	South Bend	St. Joseph	Scott, G. D.	Sullivan	Sullivan
Sarver, Francis E.	Fort Wayne	Allen	Scott, George E.	Indianapolis	Marion
Saunders, J. L.	Newport	Parke-Vermillion	Scott, H. V.	Ft. Wayne	Allen
Savage, A. R.	Ft. Wayne	Allen	Scott, Irvin H.	Sullivan	Sullivan
Savery, C. E.	South Bend	St. Joseph	Scott, I. W.	Indianapolis	Marion
Sayers, F. E.	Terre Haute	Vigo	Scott, John S.	LaPorte	LaPorte
Scamahorn, Malcolm O.	Pittsboro	Hendricks	Scott, John R.	Indianapolis	Marion
Scamahorn, O. T.	Pittsboro	Hendricks	Scott, R. F.	Kokomo	Howard
Scea, Wallace	Elwood	Madison	Scott, Robert P.	Indianapolis	Marion
Schaaf, Alvin	Jamestown	Boone	Scott, Robert S.	Charlottesville	Hancock
Schaefer, C. R. (S)	Indianapolis	Marion	Scott, S. L.	Indianapolis	Marion
Schaefer, William C.	Evansville	Vanderburgh	Scott, V. Brown	Shelbyville	Shelby
Schafer, Donald W.	Ft. Wayne	Allen	Scudder, A. N.	Brownsburg	Hendricks
Schafer, William C.	Washington	Daviess-Martin	Scudder, J. A.	Edwardsport	Knox
Schaible, E. L.	Gary	Lake	Seagle, William C.	Riverside, Calif.	Marion
Schaie, Milton	Rockville	Parke-Vermillion	Seal, Perry F.	Brookville	Fayette-Franklin
Schantz, Richard	Remington	Jasper-Newton	Seaman, C. F.	Indianapolis	Marion
Schauwecker, Cleon M.	Greencastle	Putnam	Sears, Don	Odon	Daviess-Martin
Schechter, John S.	Indianapolis	Marion	Sears, M. Maywood (S)	Elkhart	Elkhart
Scheetz, Marion R.	Lewisville	Henry	Sedam, Herbert L.	Indianapolis	Marion
Scheier, E. W.	Indianapolis	Marion	Segar, Louis H.	Indianapolis	Marion
Schell, Harry D.	Bloomington	Owen-Monroe	Seidell, Martin A.	Rochester, Minn.	Marion
Schellhouse, Earl	Fort Wayne	Allen	Seitz, P. F. D.	Indianapolis	Marion
Schenck, Foss	Logansport	Cass	Selby, K. E.	South Bend	St. Joseph
Scherb, Burton E.	Terre Haute	Vigo	Sellers, Francis M.	South Bend	St. Joseph
Scherschel, John P.	Bedford	Lawrence	Selsam, Etta B.	Terre Haute	Vigo
Schetsgen, Joseph V.	Geneva	Adams	Senese, T. J.	Gary	Lake
Scheurich, Virgil	Oxford	Benton	Sennett, C. M.	South Bend	St. Joseph
Schick, Martin F. (S)	Ft. Wayne	Allen			
Schiller, Herbert A.	South Bend	St. Joseph			



Name	City	County	Name	City	County
Sennett, Wm. K.	Macy	Miami	Simmons, L. H.	Goshen	Elkhart
Sensenich, R. L.	South Bend	St. Joseph	Simms, J. Leon	Indianapolis	Marion
Senseny, Eugene F.	Fort Wayne	Allen	Simon, A. R.	La Porte	La Porte
Senseny, Herbert	Ft. Wayne	Allen	Simpson, Wm. D.	Indianapolis	Marion
Seward, G. W.	N. Manchester	Wabash	Sims, J. Lawrence	Indianapolis	Marion
Sexson, Hiram	Indianapolis	Marion	Singer, E. C.	Ft. Wayne	Allen
Seybert, J. D.	Kendallville	Noble	Sink, Frank G.	Remington	Jasper- Newton
Seyler, Anna G.	Crown Point	Lake	Sirlin, E. M.	Mishawaka	St. Joseph
Shacklett, Henry B. (S)	New Albany	Floyd	Sisson, Helen M.	Pendleton	Madison
Shafer, J. W. (S)	Lafayette	Tippecanoe	Skeen, E. D.	Gary	Lake
Shafer, Marion R.	Indianapolis	Marion	Skilern, P. G.	South Bend	St. Joseph
Shafer, Richard H.	Alexandria	Madison	Skomp, Claud E.	Marion	Grant
Shaffer, K. L.	Vincennes	Knox	Skrentny, Stanley	Hammond	Lake
Shallenberger, H. R.	Modoc	Randolph	Slabaugh, J. S. (S)	Nappanee	Elkhart
Shanklin, E. M. (S)	Hammond	Lake	Slama, George	Gary	Lake
Shanklin, V. A.	Terre Haute	Vigo	Slama, John T.	Gary	Lake
Shanks, Ray W.	Noblesville	Hamilton	Slaughter, Howard C.	Evansville	Vanderburgh
Shanks, Roy E.	Rushville	Rush	Slaughter, John	Evansville	Vanderburgh
Shapiro, Joseph	East Chicago	Lake	Slaughter, Owen L.	Evansville	Vanderburgh
Sharman, Edward J.	Marion, Ill.	Jefferson- Switzerland	Slick, C. R.	Lynn	Randolph
Sharp, John L.	Crawfordsville	Montgomery	Sloan, H. P.	New Albany	Floyd
Sharp, Merle C.	South Bend	St. Joseph	Slominski, H. H.	South Bend	St. Joseph
Sharp, W. L.	Anderson	Madison	Sloss, I. H.	Terre Haute	Vigo
Shattuck, John C.	Brazil	Clay	Sluss, David H.	Indianapolis	Marion
Sheehan, Francis G.	Indianapolis	Marion	Sluss, John W. (S)	Indianapolis	Marion
Sheek, Kenneth I.	Greenwood	Johnson	Smallwood, R. B.	Bedford	Lawrence
Sheller, Thomas G.	Argos	Marshall	Smelser, H. W.	Connersville	Fayette- Franklin
Shelley, Edward	South Bend	St. Joseph	Smith, B. J.	Kingman	Fountain- Warren
Shellhouse, Michael	Gary	Lake	Smith, Charles G.	Otterbein	Benton
Shenk, E. M.	Kokomo	Howard	Smith, David J.	Indianapolis	Marion
Shepard, Fred F.	College Cor- ner, Ohio	Wayne-Union	Smith, D. L.	Indianapolis	Marion
Sherman, Robert M.	Bluffton	Wells	Smith, E. Rogers	Indianapolis	Marion
Sherster, Harry	Indianapolis	Marion	Smith, Francis C.	Indianapolis	Marion
Sherwood, Clarence	Fort Wayne	Allen	Smith, Frederick R.	Spencer	Owen-Monroe
Sherwood, J. V.	Ft. Wayne	Allen	Smith, G. A.	New Haven	Allen
Shields, Harry A.	Washington	Daviess- Martin	Smith, Gloster J.	Kokomo	Howard
Shields, Jack E.	Brownstown	Jackson	Smith, H. N.	Brookville	Fayette- Franklin
Shields, Tom S.	Richmond	Wayne-Union	Smith, H. S.	Bloomington	Owen-Monroe
Shinabery, Lawrence	Ft. Wayne	Allen	Smith, James M.	Indianapolis	Marion
Shively, John A.	South Bend	St. Joseph	Smith, James S.	Muncie	Delaware- Blackford
Shively, John L.	Hagerstown	Henry	Smith, Jay W.	Indianapolis	Marion
Sholty, W. M.	Lafayette	Tippecanoe	Smith, John R.	Richmond	Wayne-Union
Shonk, Harold W.	Noblesville	Hamilton	Smith, L. C.	Lafayette	Tippecanoe
Short, John	Ft. Wayne	Allen	Smith, L. W.	Warren	Huntington
Shortridge, W. H.	Seymour	Jackson	Smith, Lester A.	Indianapolis	Marion
Shoup, H. B.	Greentown	Howard	Smith, Marsh H.	Goodland	Jasper- Newton
Showalter, John P.	Waterloo	De Kalb	Smith, Paul E.	Bloomington	Owen-Monroe
Showalter, John R.	Terre Haute	Vigo	Smith, Philip L.	Ft. Wayne	Allen
Shrigley, Edw. W.	Indianapolis	Marion	Smith, Ralph O.	Vincennes	Knox
Shrock, E. E.	Amboy	Miami	Smith, Robert A.	New Castle	Henry
Shroyer, Herbert	Dunkirk	Jay	Smith, R. D. (S)	Bloomington	Owen-Monroe
Shuck, Wm. A.	Madison	Jefferson- Switzerland	Smith, R. Lee	Osgood	Ripley
Shugart, Joseph D.	Indianapolis	Marion	Smith, Richard B.	New Haven	Allen
Shullenberger, W. A.	Indianapolis	Marion	Smith, Roy L.	Indianapolis	Marion
Shulruff, H. I.	East Chicago	Lake	Smith, S. Joseph	Vincennes	Knox
Shultz, H. M. (S)	Logansport	Cass	Smith, T. J.	Whiting	Lake
Shumacker, H. B., Jr.	Indianapolis	Marion	Smith, W. E. (S)	Decatur	Adams
Sibbitt, Joseph W.	Bloomington	Owen-Monroe	Smith, Wilbur F.	Indianapolis	Marion
Sicks, O. W.	Indianapolis	Marion	Smith, William B.	Indianapolis	Marion
Sidebottom, Earl	Indianapolis	Marion	Smoot, Emory B.	Washington	Daviess- Martin
Siebenmorgen, Louis	Terre Haute	Vigo	Smoots, S. A.	Terre Haute	Vigo
Siebenmorgen, Paul	Terre Haute	Vigo	Sneary, K. D.	Avilla	Noble
Siegman, Edw. L.	Terre Haute	Vigo	Snider, Byron	Indianapolis	Marion
Siekerman, C. W.	Indianapolis	Marion	Snively, W. D., Jr.	Evansville	Vanderburgh
Siekierski, J. M.	Griffith	Lake	Snyder, E. R.	Troy	Perry
Siersdorfer, T. N.	Indianapolis	Marion	Snyder, Morris C.	Richmond	Wayne-Union
Sigmond, Harvey W.	Indianapolis	Marion	Solomon, R. A.	Indianapolis	Marion
Sigmund, Wm. B.	Columbus	Bartholomew- Brown	Solomon, Robert D.	Terre Haute	Vigo
Silbert, David	Shelbyville	Shelby	Somers, G. H.	Ft. Wayne	Allen
Silverman, Norman M.	Terre Haute	Vigo	Soper, Hunter A.	Emmettsburg, Iowa	Marion
Silver, Richard A.	Indianapolis	Marion			
Silvian, Harry	Whiting	Lake			
Simmons, Frederick H.	Marion	Grant			

Name	City	County	Name	City	County
Sorenson, Raymond	Kokomo	Howard	Stephens, K. H.	Indianapolis	Marion
Sosson, Edward	Hammond	Lake	Stephens, Lowell R.	Covington	Fountain-
Souder, Bonnell M.	Auburn	De Kalb			Warren
Sourwine, C. C.	Brazil	Clay	Stepleton, John D.	Richmond	Wayne-Union
Souter, Martha C.	Indianapolis	Marion	Stern, Nathan	Indianapolis	Marion
Southard, C. B.	Noblesville	Hamilton	Stern, S. L.	Hammond	Lake
Sovine, Joe W.	Indianapolis	Marion	Sterne, John H.	Evansville	Vanderburgh
Spahr, D. E.	Portland	Jay	Stevens, Edwin W.	Calumet City,	Lake
Spahr, John F.	Indianapolis	Marion		Ill.	
Spalding, J. J.	Indianapolis	Marion	Stevens, S. L.	Indianapolis	Marion
Spalding, W. L.	Mishawaka	St. Joseph	Stewart, Milton B. (S)	Logansport	Cass
Spangler, Jesse S.	Kokomo	Howard	Stewart, O. H.	Aurora	Dearborn-
Sparks, A. Jerome	Ft. Wayne	Allen			Ohio
Sparks, Alan L.	Indianapolis	Marion	Stewart, W. E.	Terre Haute	Vigo
Sparks, Paul W.	Winchester	Randolph	Sthair, Phillip L.	Indianapolis	Marion
Spears, John K.	Paoli	Orange	Stier, Paul L.	Ft. Wayne	Allen
Speas, Robert C.	Terre Haute	Vigo	Stillwell, William R.	Richmond	Wayne-Union
Spellman, Frank A.	Gary	Lake	Stimson, H. R.	Gary	Lake
Spencer, Beaufort A.	Bloomington	Owen-Monroe	Stinson, A. E.	Rochester	Fulton
Spencer, Frederic	Vincennes	Knox	Stinson, Dean K.	Rochester	Fulton
Spenner, R. W.	South Bend	St. Joseph	Stiver, Daniel	South Bend	St. Joseph
Spiehl, Wm. H.	Lebanon	Boone	Stocking, B. W.	Muncie	Delaware-
Spigler, James	Terre Haute	Vigo			Blackford
Spindler, Robert D.	Shelbyville	Shelby	Stoelting, J. Lewis	Terre Haute	Vigo
Spink, Urbana	Indianapolis	Marion	Stoelting, V. K.	Indianapolis	Marion
Spinning, Alva (S)	Michigan City	LaPorte	Stoler, A. E.	Ft. Wayne	Allen
Spivack, Mary	Gary	Lake	Stone, A. T.	Indianapolis	Marion
Spivey, R. J.	Indianapolis	Marion	Stone, David F.	Indianapolis	Marion
Spolyar, L. W.	Indianapolis	Marion	Stoops, Jean T.	Wabash	Wabash
Sponder, Joseph	Gary	Lake	Storer, Wm. R.	Hobart	Lake
Spray, Page E.	Elkhart	Elkhart	Storey, D. E.	Indianapolis	Marion
Springstun, C. E.	Tennyson	Warrick	Storey, Joseph L.	Indianapolis	Marion
Springstun, C. L.	Chrisney	Spencer	Stork, Harvey K.	Huntingburg	Dubois
Springstun, George	Oaktown	Knox	Stork, Urban	Evansville	Vanderburgh
Springstun, W. R.	Evansville	Vanderburgh	Storms, Roy B.	Indianapolis	Marion
Spurgeon, O. E. (S)	Muncie	Delaware-	Stouder, Albert E.	Kempton	Tipton
		Blackford	Stouder, Charles E.	Gosport	Owen-Monroe
Spurlock, Fae	W. Lafayette	Tippecanoe	Stout, Francis E.	Indianapolis	Marion
Sputh, Carl B., Sr.	Indianapolis	Marion	Stout, Harry T.	Frankfort	Clinton
Sputh, Carl B., Jr.	Indianapolis	Marion	Stout, R. B.	Elkhart	Elkhart
Sroka, Alexander G.	Hammond	Lake	Stout, Walter M.	New Castle	Henry
Sroka, Stanley J.	Highland	Lake	Stover, Wendell C.	Boonville	Warrick
	(Hammond)		Stoycoff, C. M.	Gary	Lake
Stadler, Harold E.	Indianapolis	Marion	Strange, Dempsey C.	Indianapolis	Marion
Staff, Robert A.	Rockville	Parke-	Stratigos, Jos. S.	South Bend	St. Joseph
		Vermillion	Straus, David C.	Michigan City	La Porte
Stafford, J. C.	Plainfield	Hendricks	Strayer, J. W.	Lafayette	Tippecanoe
Stafford, W. C.	Plainfield	Hendricks	Streck, F. A.	Lawrenceburg	Dearborn-
Stahl, Edward	Lafayette	Tippecanoe			Ohio
Stalter, Gaylord W.	N. Webster	Kosciusko	Strecker, Wm. L.	Terre Haute	Vigo
Stamper, J. H.	Anderson	Madison	Streepey, J. I.	New Albany	Floyd
Stamper, L. Allen	Richmond	Wayne-Union	Strickland, Karl S.	Owensville	Gibson
Stangle, W. J.	Bloomington	Owen-Monroe	Strickland, Martha B.	Lafayette	Tippecanoe
Stanley, John R.	Muncie	Delaware-	Strickland, Wm. B.	Mitchell	Lawrence
		Blackford	Strong, Daniel S.	Terre Haute	Vigo
Stanley, J. S.	Indianapolis	Marion	Stroup, Tyler J.	Indianapolis	Marion
Stanton, J. J.	Logansport	Cass	Strueh, Paul E.	Evansville	Vanderburgh
Stapleton, Pauline	W. Lafayette	Tippecanoe	Stubbins, William M.	Elkhart	Elkhart
Starks, William O.	Muncie	Delaware-	Stuckman, E. D. (S)	New Paris	Elkhart
		Blackford	Stucky, Ellsworth	Indianapolis	Marion
Stasick, Murray	Hammond	Lake	Study, Robert S.	Indianapolis	Marion
Stauffer, George E.	Mooreland	Henry	Studebaker, Lloyd R.	LaGrange	LaGrange
Stauffer, Richard C.	Ft. Wayne	Allen	Stultz, Q. F.	Ligonier	Noble
Stauffer, Walter A. (S)	Elkhart	Elkhart	Stump, Thomas A.	Indianapolis	Marion
Staunton, Henry A.	South Bend	St. Joseph	Stumpf, Edwin E.	New Haven	Allen
Stayton, C. A.	Indianapolis	Marion	Sturgis, Donald G.	Sellersburg	Clark
Stayton, Chester A., Jr.	Indianapolis	Marion	Stygall, James H.	Indianapolis	Marion
Stecy, Peter	Whiting	Lake	Sudranski, Herbert F.	Indianapolis	Marion
Steele, Dick J.	Greencastle	Putnam	Sugarman, Benj. E.	French Lick	Orange
Steele, E. B.	Crown Point	Lake	Sullenger, A. A.	Vincennes	Knox
Steele, Paul W.	Evansville	Vanderburgh	Sullivan, John M.	Terre Haute	Vigo
Steffen, A. J.	Wabash	Wabash	Sutter, Charles C.	Evansville	Vanderburgh
Steffen, J. T.	Wabash	Wabash	Sutton, Wm. E.	Indianapolis	Marion
Steffy, Ralph M.	Portland	Jay	Suzuki, Tsutomu T.	Covington	Fountain-
Steinman, H. E.	Monroeville	Allen			Warren
Stellner, Howard A.	Ft. Wayne	Allen	Swan, John R.	Indianapolis	Marion
Stemm, W. H. (S)	North Vernon	Jennings	Swan, Richard Carl	Anderson	Madison
Stephens, Donald E.	Indianapolis	Marion	Swank, L. Forrest	Elkhart	Elkhart



Name	City	County
Swayne, J. F.	Indianapolis	Marion
Sweet, Howard E.	Richmond	Wayne-Union
Swihart, Homer R.	Elkhart	Elkhart
Swihart, L. F.	Elkhart	Elkhart
Switzer, Robert E.	Bethesda, Md.	Noble
Symmes, Alfred T.	Indianapolis	Marion
Szynal, John S.	Indianapolis	Marion

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Tager, Stephen	Evansville	Vanderburgh
Take, J. F. (S)	French Lick	Orange
Talbert, Pierre C.	Bluffton	Wells
Talbott, Dan E.	Indianapolis	Marion
Tanner, Henry S.	Indianapolis	Marion
Taube, Jack I.	Indianapolis	Marion
Taylor, C. C.	Indianapolis	Marion
Taylor, E. C.	Upland	Grant
Taylor, Eugene C.	Evansville	Vanderburgh
Taylor, Eugene E.	W. Lafayette	Tippecanoe
Taylor, F. W.	Indianapolis	Marion
Taylor, James A. (S)	Montpelier	Delaware-Blackford
Taylor, Lon S.	Elberfeld	Warrick
Taylor, W. H.	Ambia	Benton
Taylor, W. R.	Richmond	Wayne-Union
Teaford, S. F. (S)	Paoli	Orange
Teague, Frank	Indianapolis	Marion
Teal, Dorothy D.	Columbus	Bartholomew-Brown

Teegarden, J. A., Jr.	East Chicago	Lake
Teegarden, J. A., Sr.	East Chicago	Lake
Teixler, V. A.	Indianapolis	Marion
Templeton, Ames R.	Mishawaka	St. Joseph
Templin, D. B.	Gary	Lake
Tennant, David L.	Ft. Wayne	Allen
Tennis, George	Greencastle	Putnam
Teplinsky, L. Louis	Munster	Lake
Terfinger, F. W. (S)	Logansport	Cass
Terrill, R. W.	Ft. Wayne	Allen
Terry, Lloyd	Danville	Hendricks
Terveer, John B.	Decatur	Adams
Test, Charles E.	Indianapolis	Marion
Test, Pasquale S.	Indianapolis	Marion
Teter, Geo. V., Jr.	Indianapolis	Marion
Teters, Melvin S.	Middlebury	Elkhart
Tether, Joseph E., Jr.	Indianapolis	Marion
Tetrick, Elbert L.	Evanston, Ill.	Marion
Tharp, Harold R.	Indianapolis	Marion
Tharpe, Ray	Indianapolis	Marion
Thatcher, H. K., Jr.	Indianapolis	Marion
Thayer, B. W.	North Vernon	Jennings
Thayer, J. O.	Noblesville	Hamilton
Thegze, George	Whiting	Lake
Theye, Richard A.	Indianapolis	Marion
Thill, Leonard J.	Ashley	De Kalb
Thimlar, J. W.	Ft. Wayne	Allen
Thom, Jay W.	Indianapolis	Marion
Thom, Julia S.	Indianapolis	Marion
Thomas, C. E. (S)	Leesburg	Kosciusko
Thomas, Daniel D.	Gary	Lake
Thomas, Edward P.	Indianapolis	Marion
Thomas, Everett W.	Warsaw	Kosciusko
Thomas, Fred A.	Indianapolis	Marion
Thomas, G. A.	Lafayette	Tippecanoe
Thomas, Gerald J.	Gary	Lake
Thomas, Lowell I.	Indianapolis	Marion
Thomas, Morris E.	Indianapolis	Marion
Thomas, Ralph G.	Indianapolis	Marion
Thompson, A. A.	Tyner	Marshall
Thompson, Chas. F.	Indianapolis	Marion
Thompson, Frank	Columbia City	Whitley
Thompson, Holland	Ft. Wayne	Allen
Thompson, John M.	South Bend	St. Joseph
Thompson, J. V.	Indianapolis	Marion
Thompson, Lewis	New Harmony	Posey
Thompson, Noah (S)	Bedford, Va.	Wabash
Thompson, Paul D.	Indianapolis	Marion
Thompson, Robert A.	South Bend	St. Joseph

Name	City	County
Thompson, W. A.	Liberty	Wayne-Union
Thompson, Wm. R.	Winamac	Pulaski
Thornburg, Kenneth	Indianapolis	Marion
Thorne, C. E.	New Castle	Henry
Thornton, Harold C.	Indianapolis	Marion
Thornton, Maurice J.	South Bend	St. Joseph
Thornton, Walter E.	Ft. Wayne	Allen
Thrasher, John R.	Indianapolis	Marion
Thurston, H. S. (S)	Indianapolis	Marion
Tilden, Margaret	Evansville	Vanderburgh
Tiley, George	Greenwood	Johnson
Tilka, Edward	Hammond	Lake
Tindal, E. F. (S)	Muncie	Delaware-Blackford
Tindall, George T.	Indianapolis	Marion
Tindall, Paul R.	Shelbyville	Shelby
Tindall, Wm. R.	Shelbyville	Shelby
Tinney, W. E.	Indianapolis	Marion
Tinsley, Frank W.	Indianapolis	Marion
Tinsley, W. B.	Indianapolis	Marion
Tipton, Wm. R.	Greencastle	Putnam
Tirman, Wallace S.	Bluffton	Wells
Tischer, E. Paul	Indianapolis	Marion
Titus, Charles (S)	Wilkinson	Hancock
Todd, David D.	Elkhart	Elkhart
Tomak, Milton E.	Linton	Greene
Tomlin, Hugh M.	Muncie	Delaware-Blackford
Tomlinson, C. H. (S)	Cicero	Hamilton
Topek, Nathan H.	Indianapolis	Marion
Topolugus, James N.	Bloomington	Owen-Monroe
Topping, M. C.	Terre Haute	Vigo
Torella, J. A.	Indianapolis	Marion
Toumey, Fred L.	Indianapolis	Marion
Tower, Thomas K.	Campbellsburg	Washington
Townsend, Ralph	Westville	LaPorte
Tracy, Julius R.	Anderson	Madison
Tranter, W. F.	Sharpsville	Tipton
Traver, P. C.	South Bend	St. Joseph
Travis, J. C., Jr.	Logansport	Cass
Tremain, M. A. (S)	Adams	Decatur
Treon, James F.	Aurora	Dearborn-Ohio
Trepagnier, Francis B.	East Chicago	Lake
Trinosky, Donald L.	Gary	Lake
Tripp, H. D.	Bloomington	Owen-Monroe
Trout, C. J.	Lafayette	Tippecanoe
Troutwine, William	Crown Point	Lake
Troy, Jack M.	Whiting	Lake
Truman, Elmer M., Jr.	Rushville	Rush
Trusler, H. M.	Indianapolis	Marion
Tubbs, George R. (S)	Lafayette	Tippecanoe
Tuchman, Joseph H.	Indianapolis	Marion
Tucker, O. A.	Daleville	Delaware-Blackford
Tucker, Robert L.	Indianapolis	Marion
Tucker, Warren S.	Indianapolis	Marion
Tully, J. A. (S)	New Castle	Henry
Turgi, Robert W.	Gary	Lake
Turley, Verne L.	Fowler	Benton
Turner, Anna Goss	Madison	Jefferson-Switzerland
Turner, H. B.	Bloomfield	Greene
Turner, Jack J.	Bloomfield	Greene
Turner, John P.	Goshen	Elkhart
Turner, Maurice A.	Oakland City	Gibson
Turner, Oscar A.	Madison	Jefferson-Switzerland
Turner, Robert	Muncie	Delaware-Blackford
Tweedall, D. C.	Evansville	Vanderburgh
Tweedall, D. G.	Evansville	Vanderburgh
Tyler, F. T.	New Albany	Floyd
Tyner, Harlan H.	Indianapolis	Marion
Tyrrell, Thomas C.	Calumet City, Ill.	Lake

Name	City	County	Name	City	County
U					
Uhrich, John H.	Monroeville	Allen	Wagoner, John B.	Delphi	Carroll
Underwood, G. B.	Evansville	Vanderburgh	Wagoner, Robert H. (S)	Colburn	Tipppecanoe
Urschel, Dan L.	Mentone	Kosciusko	Waite, Earl L.	Macy	Miami
Utterback, Arnold	Terre Haute	Vigo	Waits, Chester L.	Colfax	Clinton
V			Waldo, J. Thayer	Indianapolis	Marion
Vagner, Bernard	South Bend	St. Joseph	Walerko, Frank	Mishawaka	St. Joseph
Vail, George A.	Lawrenceburg	Dearborn- Ohio	Walker, Adolph B.	Hammond	Lake
VanArsdall, C. R.	Terre Haute	Vigo	Walker, F. C.	Indianapolis	Marion
VanBokkelen, Robert	Mooreville	Morgan	Walker, Floyd B.	Fort Wayne	Allen
VanBuskirk, E. L.	Lafayette	Tipppecanoe	Walker, Jack M.	Plainfield	Hendricks
Vance, Wm. C.	Richmond	Wayne- Union	Walker, J. L.	LaFontaine	Wabash
Vandever, Arthur	Sellersburg	Clark	Walker, Robert K.	Indianapolis	Marion
Vandivier, R. M.	Indianapolis	Marion	Wall, Joseph A.	Wabash	Wabash
VanDorn, Myron J.	Indianapolis	Marion	Wallace, Hawthorne C.	Crawfordsville	Montgomery
VanFleet, Josephine	Indianapolis	Marion	Waller, William	Angola	Steuben
Van Kirk, George H.	Kentland	Jasper- Newton	Walters, Charles E.	Mishawaka	St. Joseph
VanKirk, J. A.	Frankfort	Clinton	Walters, Eleanore	Gary	Lake
VanKirk, John R.	Burlington	Carroll	Walters, William	Michigan City	LaPorte
VanKirk, Paul P.	Frankfort	Clinton	Walther, Joseph E.	Indianapolis	Marion
VanMeter, C. Powell	Indianapolis	Marion	Waltz, Frank C.	Mentone	Kosciusko
VanNess, William C.	Summitville	Madison	Wanninger, Horace	Richmond	Wayne- Union
VanNest, W. A.	New Smyrna Beach, Fla.	Dekalb	Ward, H. H. (S)	Coalmont	Clay
Van Nuys, John D.	Indianapolis	Marion	Ward, J. W.	Mishawaka	St. Joseph
VanNuys, W. C. (S)	New Castle	Henry	Ward, Jos. H.	Indianapolis	Marion
VanOsdol, H. A.	Indianapolis	Marion	Ward, Wesley C.	Indianapolis	Marion
Van Rie, L. P.	Mishawaka	St. Joseph	Ware, J. R.	Huntington	Huntington
Van Sandt, Frank A. (S)	Bloomfield	Greene	Warfel, F. C.	Indianapolis	Marion
VanTassel, Charles J.	Santa Ynez, Calif.	Marion	Warfield, Chester H.	Ft. Wayne	Allen
VanVactor, Helen D.	Indianapolis	Marion	Warman, A. P.	Indianapolis	Marion
VanWinkle, Arthur J.	Valparaiso	Porter	Warn, William J.	Milan	Ripley
Varble, William (S)	Jeffersonville	Clark	Warne, G. H.	Tipton	Tipton
Veach, Lester W.	Bainbridge	Putnam	Warren, Frank R. (S)	Michigan City	LaPorte
Veach, Richard L.	Bainbridge	Putnam	Warren, Carroll B.	Marion	Grant
Veazey, Wm. (S)	Avilla	Noble	Warrick, Francis B.	Richmond	Wayne- Union
Venable, George L.	N. Manchester	Wabash	Warrick, Homer L.	Osceola	St. Joseph
Venis, Kemper N.	Muncie	Delaware- Blackford	Warriner, James B.	Indianapolis	Marion
Vermilya, R. W.	Lafayette	Tipppecanoe	Warvel, J. H.	Indianapolis	Marion
Verplank, G. L.	Gary	Lake	Warvel, Joseph L. (S)	N. Manchester	Wabash
Viehe, Robert W.	Evansville	Vanderburgh	Washburn, W. W.	Lafayette	Tipppecanoe
Vietzke, P. C. F.	Valparaiso	Porter	Washington, G. Kenneth	Gary	Lake
Vingus, Bronie	Greenfield	Hancock	Watson, James L.	Evansville	Vanderburgh
Viney, Charles L.	Logansport	Cass	Watterson, Gerald T.	Connersville	Fayette- Franklin
Visher, John S.	Berkeley, Calif	Vanderburgh	Waymire, E. S.	Indianapolis	Marion
Visher, John W.	Evansville	Vanderburgh	Weaver, T. M. (S)	Brazil	Clay
Vivian, Donald E.	New Castle	Henry	Weaver, Wm. W.	New Albany	Floyd
Vlaskamp, Elaine	Muncie	Delaware- Blackford	Webb, Harry D.	Anderson	Madison
Vogel, L. John	Mt. Vernon	Posey	Weber, Edgar H.	Evansville	Vanderburgh
Voges, Edward C.	Terre Haute	Vigo	Weber, John R.	Ft. Wayne	Allen
Voisinet, R. A.	Union City	Randolph	Weber, Joseph G. S.	Terre Haute	Vigo
Vollrath, Victor J.	Indianapolis	Marion	Webster, Paul L.	Ligonier	Noble
VonAsch, George	LaPorte	LaPorte	Webster, R. K.	Brazil	Clay
Vore, Hugh A.	Highland	Lake	Weddle, Chas. O.	Lebanon	Boone
Vore, L. W.	Plymouth	Marshall	Weeks, P. H.	Michigan City	LaPorte
Voyles, C. F. (S)	Indianapolis	Marion	Weems, M. P.	Jeffersonville	Clark
Voyles, Harry	New Albany	Floyd	Wegner, William G. (S)	South Bend	St. Joseph
Vyppillat, Francis J.	South Bend	St. Joseph	Wehrman, J. O. (S)	Indianapolis	Marion
Vye, James P.	Gary	Lake	Weigand, C. G.	Indianapolis	Marion
W			Weil, H. J.	Indianapolis	Marion
Wade, A. A.	Howe	LaGrange	Weinberg, B. A.	Whiting	Lake
Wagner, Arthur L.	Jasper	Dubois	Weinberg, Samuel	Marion	Grant
Wagoner, G. W.	Delphi	Carroll	Weinland, George C.	Indianapolis	Marion
			Weinstein, E. B.	Richmond	Wayne- Union
			Weinstein, J. H. (S)	Terre Haute	Vigo
			Weinstock, Adolph	Rolling Prairie	LaPorte
			Weir, Dale	LaGrange	LaGrange
			Weirich, Charles I.	Butler	Dekalb
			Weis, William D. (S)	Crown Point	Lake
			Weiskopf, Henry S.	Gary	Lake
			Weiss, Eugene	South Bend	St. Joseph
			Weiss, H. G. (S)	Evansville	Vanderburgh



Name	City	County	Name	City	County
Weiss, Jason	Indianapolis	Marion	Williams, H. O.	Kendallville	Noble
Weitzel, Roland	Princeton	Gibson	Williams, H. S., Jr.	Indianapolis	Marion
Welborn, Mell B.	Evansville	Vanderburgh	Williams, Hugh L.	Indianapolis	Marion
Welch, Norbert M.	Vincennes	Knox	Williams, John H.	Muncie	Delaware- Blackford
Weldy, Bryce P.	Hartford City	Delaware- Blackford	Williams, Paul D.	Richmond	Wayne-Union
Weller, Charles A.	Indianapolis	Marion	Williams, Robert D.	Markleville	Madison
Wellpott, Jean F.	Bloomington	Owen-Monroe	Williams, R. H.	Anderson	Madison
Welty, S. G.	Ft. Wayne	Allen	Willis, Charles F.	Evansville	Vanderburgh
Werry, L. E.	Hartford City	Delaware- Blackford	Willison, George	Evansville	Vanderburgh
Wertemberger, Morris D.	Richmond	Wayne- Union	Willner, Alan	Clarksville	Clark
Wesson, Thomas W.	Evansville	Vanderburgh	Wills, Benjamin F.	Union City	Randolph
West, Joseph L.	Indianapolis	Marion	Wills, Max	Auburn	DeKalb
Westfall, B. Kemper	Indianapolis	Marion	Willson, C. L.	Anderson	Madison
Westfall, George S.	Goshen	Elkhart	Wilmore, Ralph C.	Indianapolis	Marion
Westfall, John B.	Indianapolis	Marion	Wilson, Douglas E.	Indianapolis	Marion
Weyerbacher, A. F.	Indianapolis	Marion	Wilson, Fred	Terre Haute	Vigo
Whallon, Arthur J.	Richmond	Wayne- Union	Wilson, Fred M.	Indianapolis	Marion
Wharton, R. O.	Gary	Lake	Wilson, Guy	Bicknell	Knox
Whipps, Charles E.	Carlisle	Sullivan	Wilson, James	South Bend	St. Joseph
Whisler, F. M.	Wabash	Wabash	Wilson, John D.	Evansville	Vanderburgh
Whitcomb, Roger F.	Shelbyville	Shelby	Wilson, John W.	Indianapolis	Marion
White, C. S.	Rosedale	Parke- Vermillion	Wilson, Leslie	Ft. Wayne	Allen
White, Donald J.	Indianapolis	Marion	Wilson, O. E.	Elkhart	Elkhart
White, Harvey E.	Farmland	Randolph	Wilson, Oliver R.	Indianapolis	Marion
White, I. D. (S)	Clinton	Parke- Vermillion	Wilson, Paul	Boonville	Warrick
White, James V.	Terre Haute	Vigo	Wilson, P. H.	Logansport	Cass
White, John B.	Indianapolis	Marion	Wilson, R. C.	Franklin	Johnson
White, Philip T.	Rochester, Minn.	Marion	Wilson, Ralph	Evansville	Vanderburgh
White, W. J. (S)	Gary	Lake	Wilson, Ralph (S)	Shirley	Henry
Whitehead, John M.	Indianapolis	Marion	Wilson, Roland B.	Ft. Wayne	Allen
Whitlock, Francis C.	Mishawaka	St. Joseph	Wilson, T. L.	Bloomington	Owen- Monroe
Whitlock, Merle E.	Mishawaka	St. Joseph	Wimmer, Robert N.	Gary	Lake
Whitsitt, S. A. (S)	Madison	Jefferson- Switzerland	Winter, Donald K.	Logansport	Cass
Whitt, James D.	Chattanooga, Tenn.	Marion	Winterhoff, Ernest H.	Springfield, O.	Marion
Wicker, Eugene H.	Marion	Grant	Winters, Matthew	Indianapolis	Marion
Wicks, O. C. (S)	Gary	Lake	Wise, Charles L.	Camden	Carroll
Wiedemann, F. E. (S)	Terre Haute	Vigo	Wise, Wm.	Indianapolis	Marion
Wiersma, Alvin F.	Marion	Grant	Wiseheart, O. H. (S)	North Salem	Hendricks
Wierzalis, Edward F.	Hartford City	Delaware- Blackford	Wiseheart, Robert	Lebanon	Boone
Wiethoff, Clifford Allen	Seymour	Jackson	Wiseman, V. Earle	Greencastle	Putnam
Wiggins, D. S. (S)	New Castle	Henry	Wisener, G. H.	Richmond	Wayne- Union
Wilcox, R. F.	LaPorte	LaPorte	Wishard, Wm. N., Jr.	Indianapolis	Marion
Wilder, G. B.	Anderson	Madison	Wishart, S. W.	Evansville	Vanderburgh
Wildman, R. E.	Peru	Miami	Wissman, William L.	Columbus	Bartholomew- Brown
Wilhelm, Agatha M.	South Bend	St. Joseph	Witham, Robert L.	Culver	Marshall
Wilhelmus, C. Kenneth	Evansville	Vanderburgh	Witt, William R.	New Albany	Floyd
Wilhelmus, Charles M.	Newburgh	Warrick	Wixted, John F.	Mishawaka	St. Joseph
Wilhelmus, Gilbert	Evansville	Vanderburgh	Wixted, Julia F.	Mishawaka	St. Joseph
Wilhelmus, Wm. M.	Evansville	Vanderburgh	Wohlfeld, Gerald	New Albany	Floyd
Wilkens, I. W.	Indianapolis	Marion	Wohlfeld, J. B.	Bedford	Lawrence
Wilkerson, Edward L.	Terre Haute	Vigo	Wolfe, Nelson	New Albany	Floyd
Wilkins, R. W.	Ft. Wayne	Allen	Wolfram, Don J.	Indianapolis	Marion
Wilkinson, Roger L.	Anderson	Madison	Woner, John W.	Linton	Greene
Willan, H. R.	Martinsville	Morgan	Wood, Amelia T.	Muncie	Delaware- Blackford
Williams, A. H.	Ft. Wayne	Allen	Wood, Donald E.	Indianapolis	Marion
Williams, Alexander S.	Gary	Lake	Wood, Elmer U. (S)	Columbus	Bartholomew- Brown
Williams, Berniece	Ft. Wayne	Allen	Wood, Frederick H.	Hammond	Lake
Williams, Charles D.	Indianapolis	Marion	Wood, Opal L.	Brazil	Clay
Williams, C. L.	Indianapolis	Marion	Wood, R. W.	Oakland City	Gibson
Williams, Everett W.	Columbus	Bartholomew- Brown	Woodall, Earl C.	Indianapolis	Marion
Williams, F. M., Jr.	Anderson	Madison	Woodard, Abram S., Jr.	Indianapolis	Marion
Williams, F. P.	Huntingburg	Dubois	Woodcock, C. E.	Greenwood	Johnson
Williams, Frederic N.	Mt. Vernon	Posey	Woods, A. L.	Poseyville	Posey
Williams, H. J.	Morocco	Jasper- Newton	Woods, H. C.	Markle	Huntington
			Woods, James R.	Greenfield	Hancock
			Woods, Wm. P. (S)	Evansville	Vanderburgh
			Woolery, R. H.	Bedford	Lawrence
			Work, Bruce A.	Frankfort	Clinton
			Work, James A., Jr.	Elkhart	Elkhart

Name	City	County	Name	City	County
Worley, A. C.	Ft. Wayne	Allen	Young, C. Curtis	Evansville	Vanderburgh
Worley, J. P.	Indianapolis	Marion	Young, E. M. (S)	Sheridan	Hamilton
Worley, Richard H.	Indianapolis	Marion	Young, G. M.	Gary	Lake
Worth, C. W.	Milroy	Rush	Young, G. S.	Muncie	Delaware- Blackford
Wright, Cecil S.	Anderson	Madison	Young, James W.	Indianapolis	Marion
Wright, J. Wm., Jr.	Indianapolis	Marion	Young, John E.	Indianapolis	Marion
Wright, J. William	Indianapolis	Marion	Young, John M.	Indianapolis	Marion
Wright, W. C.	Ft. Wayne	Allen	Young, Ralph H.	Goshen	Elkhart
Wurster, H. C.	Mishawaka	St. Joseph	Young, Robert	Marion	Grant
Wyatt, Fred H.	Denver,	Vanderburgh	Young, Robert L.	Gary	Lake
	Colorado		Young, S. J. (S)	Kendallville	Noble
Wyatt, James L., II	Ft. Wayne	Allen	Young, W. C.	Indianapolis	Marion
Wyatt, James L., III	Ft. Wayne	Allen	Yunker, P. E.	Howe	LaGrange
Wyeth, Charles (S)	Terre Haute	Vigo		Z	
Wygant, M. D.	Mishawaka	St. Joseph	Zalac, Donald	Indianapolis	Marion
Wyland, B. J.	Mishawaka	St. Joseph	Zallen, Stanley G.	East Chicago	Lake
Wynn, J. F.	Evansville	Vanderburgh	Zaring, B. K.	Columbus	Bartholomew- Brown
Wynne, R. E.	Bedford	Lawrence	Zehr, Noah	Ft. Wayne	Allen
Wyttenbach, Frederick	Indianapolis	Marion	Zeiger, Irvin	South Bend	St. Joseph
Wyttenbach, John E.	Indianapolis	Marion	Zell, Evertson H.	Indianapolis	Marion
	Y		Zeman, Theodore C.	Hammond	Lake
Yale, Charles A.	Winamac	Pulaski	Zeps, E. Frances	Iowa Cy., Iowa	Marion
Yarling, J. E. (S)	Peru	Miami	Zerfas, Charles P. A.	Indianapolis	Marion
Yarrington, C. W. (S)	Gary	Lake	Zerfas, L. G.	Camby	Marion
Yeck, Charles W.	Evansville	Vanderburgh	Zerfas, Phyllis	Indianapolis	Marion
Yegerlehner, Roscoe	Kentland	Jasper- Newton	Zierer, R. O.	Anderson	Madison
Yencer, M. W. (S)	Richmond	Wayne- Union	Zimmer, Henry J.	Mishawaka	St. Joseph
Yochem, August S., Jr.	Chelsea,	Marion	Zimmerman, Harold	Evansville	Vanderburgh
	Mass.		Zimmerman, Wm. H.	Dublin	Wayne-Union
Yocum, Paul S.	Gary	Lake	Zink, Robert O.	Madison	Jefferson- Switzerland
Yocum, William S.	Gary	Lake	Ziperman, H. Haskell	Mt. Holly, N.J.	Marion
Yoder, Albert C.	Goshen	Elkhart	Zivich, John M.	East Chicago	Lake
Yoder, D. D.	Columbus	Bartholomew- Brown	Zweig, E. S.	Ft. Wayne	Allen
Yoder, C. Richard	Elkhart	Elkhart	Zwerner, Paul F.	Terre Haute	Vigo
Yoder, Richard P.	Bluffton	Wells	Zwick, Harold F.	Decatur	Adams
York, Arthur F.	Anderson	Madison	Zwickel, R. E.	Cleveland, O	Warrick

## ROSTER OF MEMBERS BY COUNTIES

Physicians are listed in the counties in which they reside.

(Paid up members of the Indiana State Medical Association as of June 1, 1952)

### ADAMS COUNTY

Beaver, Norman ..... Berne  
Habegger, Myron L. .... Berne  
Jones, D. D. (S) ..... Berne  
Lehman, Harold ..... Berne  
Reusser, Amos (S) ..... Berne  
Burk, James M. .... Decatur  
Carroll, John C. .... Decatur  
Girod, Arthur H. .... Decatur  
Kohne, Gerald J. .... Decatur  
Parrish, Richard K. .... Decatur  
Rayl, Claudius C. .... Decatur  
Reppert, Roland L. .... Decatur  
Smith, Waldo E. (S) .... Decatur  
Terveer, John B. .... Decatur  
Zwick, Harold F. .... Decatur  
Hinchman, Clarence P. .... Geneva  
Schetgen, Joseph V. .... Geneva

### ALLEN COUNTY

#### Fort Wayne

#### A

Aiken, Arthur F. .... 1923 E. State  
Aiken, Nevin E. .... 1923 E. State St.

#### B

Bailey, Paul P.  
206 Medical Center Bldg. (2)  
Baltes, Jos. H. .... 821 Broadway (2)  
Bash, Wallace E. .... 111 Esmond  
Baumgartner, J. C.  
515 W. Wayne St. (2)  
Beams, Ralph  
517 Medical Center Bldg. (2)  
Beierlein, Karl M.  
629 Medical Center Bldg. (2)  
Benninghoff, D. R.  
208 Medical Center Bldg. (2)  
Bergendahl, Emil H.  
2901 Fairfield Ave. (6)  
Berghoff, R. J. .... 306 E. Jefferson (2)  
Bickel, J. E. (S)  
2615 S. Lafayette (2)  
Blosser, H. V. (S) .... 309 W. Main (2)  
Bolman, Ralph M. .... 717 Broadway  
Borders, Theodore R.  
1145 S. Lafayette (2)  
Bowers, G. T. .... 307 E. Jefferson (2)  
Bowers, J. W. .... 418 Gettle Bldg.  
Brosius, R. H. W. .... 1603 Wells (7)  
Brown, F. W. .... 335 Lincoln Bk. Tr.

#### Bruggeman, H. O.

1202 Washington St.  
Bryan, Franklin A.  
402 W. Washington Blvd.  
Buckner, Doster  
533 W. Washington St.  
Buckner, George D.  
533 W. Washington St.  
Bulson, Eugene L.  
102 Medical Center Bldg. (2)

#### C

Calvin, J. C. (S) .... 312 W. Wayne (2)  
Cameron, Don F.  
702 Medical Center Bldg. (2)  
Carey, Willis W. (S)  
2525 S. Calhoun (5)  
Carlo, E. R. .... 2902 Fairfield (6)  
Cartwright, E. L.  
230 Medical Center Bldg. (2)  
Catlett, M. B. .... 232 W. Wayne (2)  
Chambers, A. R. .... 601 W. Wayne (2)  
Clark, W. R. .... 3622 S. Calhoun St.  
Conley, J. E. .... 620 W. Berry (2)  
Cooney, C. J. .... 527 W. Berry (2)  
Cornell, B. S. .... 435 Lincoln Bk. Tr.  
Culp, J. E. .... 2902 Fairfield (6)



## ALLEN COUNTY

## (Fort Wayne—Continued)

## D

Dancer, C. R. (S)  
905 Columbia Ave.  
Datzman, Richard C.  
525 Medical Center Bldg. (2)  
Ditton, I. W. (S). 1214 E. Wayne (4)  
Duemling, A. H. 2902 Fairfield (6)  
Dunstone, H. C.  
502 Medical Center Bldg. (2)

## E

Edlavitch, B. M. . . . 716 Rockhill (2)  
Elston, Lynn W.  
622 Medical Center Bldg. (2)  
Elston, Ralph W.  
622 Medical Center Bldg. (2)  
Emenhiser, John L.  
R. 9, Maysville Rd.  
Estlick, R. E.  
629 Medical Center Bldg. (2)

## F

Fichman, A. M. . . 323 W. Berry (2)  
Foy, H. W. . . . . 1747 Wells St.

## G

Garton, H. W. . . . . 1635 Broadway  
Gerding, W. J. . . . 2638½ S. Calhoun  
Gessler, W. F. . . . 2902 Fairfield (6)  
Gladstone, N. H. . . 335 W. Berry (2)  
Glock, H. E.  
324 Medical Center Bldg. (2)  
Glock, M. E. . . . . 312 W. Wayne (2)  
Glock, W. R. . . 335 Lincoln Bk. Tower  
Goebel, Carl W.  
213 W. Jefferson St.  
Gould, L. K. . . . 3415 S. Fairfield (6)  
Graham, George M.  
Lincoln Nat. Life Ins. Co.  
Greist, Walter D.  
2902 Fairfield Ave. (6)

## H

Haffner, H. G. 202 E. Jefferson (2)  
Haller, Robert L.  
604 W. Wayne St.  
Hamilton, E. D.  
2405 Florida Dr. (3)  
Harshman, L. P.  
2704 N. Clinton (3)  
Harvey, H. C. . . . 1202 E. State (3)  
Hasewinkle, A. M. . 1129 E. State (3)  
Hastings, Warren C. 811 Ewing St.  
Hattendorf, A. P.  
725 Medical Center Bldg. (2)  
Havens, R. E.  
1845 Kensington Blvd.  
Hiatt, Russell L. Veterans Hospital  
Hoffman, A. F. . . . 233 E. Jefferson  
Hoffmann, S. P.  
424 Medical Center Bldg. (2)  
Horton, G. R. . . . 527 W. Berry St.  
Howe, F. L. . . . . 1525 Oxford St.

## J-K

Jackson, John F. 617 Forest Ave.  
Johnston, Richard M.  
312 Medical Center Bldg. (2)  
Jurgensen, W. T. . . 3415 Fairfield

Karol, Herbert J.  
624 Medical Center Bldg.  
Keck, Carleton A.  
2902 Fairfield Ave. (2)  
Kent, Richard N.  
731 Medical Center Bldg. (2)  
Kidder, O. T. . . . Irene Byron San.  
Kimbrough, Robert F.  
618 Medical Center Bldg. (2)  
Kissinger, Charles C.  
Veterans Hospital  
Kleifgen, William A.  
617 W. Washington St.  
Kruse, E. H. . . . 705 Lincoln Tr. (2)  
Kruse, Walter E.  
512 Medical Center Bldg. (2)

## L

Ladig, D. S. . . . . 337 E. Berry (2)  
Lehner, J. J.  
323 Medical Center Bldg. (2)  
Leming, Ben L.  
1135 Lincoln Bank Bldg.  
Lenk, G. G. . . . . 2007 Maumee (4)  
Lloyd, Robert P. . . 717 Broadway  
Lohman, R. M.  
229 Medical Center Bldg. (2)  
Loudermilk, Jack L.  
525 Medical Center Bldg. (2)

## M

Mackel, Frederick O.  
335 Lincoln Bank Bldg.  
Manning, George . . 811 Ewing St.  
McArdle, E. G. 2201 S. Calhoun (5)  
McCabe, T. E. . . . 803 S. Calhoun  
McCallister, John W.  
711 Medical Center Bldg. (2)  
McCoy, R. R. . . . 3701 S. Harrison (6)  
McDowell, G. A.  
215 Medical Center Bldg. (2)  
McEachern, Cecil G.  
701 Medical Center Bldg. (2)  
McFall, J. R. S. . . 1706 Sherman  
McKeeman, Donald H.  
633 W. Wayne St. (2)  
McKeeman, L. S.  
304 Medical Center Bldg. (2)  
McNairy, Donald J.  
710 Medical Center Bldg. (2)  
Mendenhall, Edgar  
208 Medical Center Bldg. (2)  
Mercer, Samuel R.  
710 Medical Center Bldg. (2)  
Meyer, H. A. . . . 1030 W. Wayne (2)  
Meyer, T. O.  
228 Medical Center Bldg.  
Michaelis, S. C. . . 2154 Fairfield (6)  
Miller, C. G. . . . 229 W. Wayne (2)  
Miller, H. Paul . . . 2809 Broadway  
Miller, Mahlon F.  
334 Medical Center Bldg. (2)  
Miller, O. J. . . . . 324 W. Berry (2)  
Miller, R. H. . . . 511 W. Wayne (2)  
Moats, C. F. . . . 4007 S. Wayne (6)  
Moats, G. E. 615 E. Washington St.  
Moravec, A. E. 705 Lincoln Tr. (2)  
Mortenson, L. J.  
214 Medical Center Bldg. (2)  
Mueller, L. W. . . . 533 W. Wash.  
Murdock, H. L.  
521 Medical Center Bldg. (2)

## N-O

Nahrwold, E. W.  
417 Medical Center Bldg. (2)  
Nill, J. H. . . . . 1024 S. Barr (2)  
O'Rourke, C. . . . . 604 W. Berry (2)  
Oyer, J. H. . . . 2707½ S. Calhoun St.

## P

Painter, Donald S.  
222 Medical Center Bldg. (2)  
Parker, C. B. . . . 1105 S. Harrison St.  
Perrin, K. F. . . . 2701 S. Anthony St.  
Perry, F. G. . . . . 2902 Fairfield (6)  
Phillips, John F. 3418 S. Hanna St.  
Popp, Milton F.  
610 Medical Center Bldg. (2)  
Porter, Miles F., Jr.  
501 Dime Bank Bldg. (2)  
Prentiss, Nelson H.  
276 Central Bldg. (2)

## Q-R

Rabson, S. M. . . . 730 W. Berry St.  
Ranke, John W. Henry (S)  
3112 Beaver Ave. (6)  
Rawles, L. T. . . . 3131 Fairfield (6)  
Ray, Herbert A. (S)  
402 Medical Center Bldg. (2)  
Rice, W. B. . . . . 1101 E. Pontiac (5)  
Rissing, W. J. . . . 3200 Irvington  
Rockey, N. A. . . . 1224 E. State (3)  
Rodriguez, J. . . . 2902 S. Fairfield (6)  
Roser, A. J. . . . . 617 W. Washington  
Rossiter, D. L. . . . 103½ E. Pontiac  
Rothberg, Maurice  
712 Medical Center Bldg. (2)  
Rothschild, C. J.  
319 Medical Center Bldg. (2)

## S

Sahlmann, H. . . . 1320 Broadway (2)  
Salon, H. W. . . . . 535 W. Berry (2)  
Salon, Nathan L. . . 604 W. Wayne  
Sarver, Francis E. . 717 Broadway  
Savage, A. R. . . . 302 W. Berry (2)  
Schafer, D. W. . . . 221 W. Wayne St.  
Schellhouse, Earl . . 1240 W. Main  
Schick, Martin F. (S)  
401 W. Washington (2)  
Schlademan, Karl R.  
516 Medical Center Bldg. (2)  
Schlegel, Edward H. 1129 Maumee  
Schmidt, Eugene E.  
312 Medical Center Bldg. (2)  
Schmoll, R. J. . . . 604 W. Berry St.  
Schneider, L. H. . . 730 W. Berry St.  
Schoen, Frederic L.  
604 W. Wayne St.  
Scoins, W. H. . . . 1301 S. Harrison  
Scott, H. V. . . . . 2902 Fairfield (6)  
Senseny, Eugene F.  
116 W. Rudisell Blvd.  
Senseny, Herbert  
314 Medical Center Bldg. (2)  
Sherwood, Clarence E.  
Irene Byron Sanitarium  
Sherwood, J. V.  
Irene Byron Sanitarium  
Shinabery, L. . . . 1850 Broadway (6)  
Short, J. T. . . . . 2902 Fairfield (6)  
Singer, Elmer C.  
310 Medical Center Bldg. (2)  
Smith, Philip L.  
2902 Fairfield (6)  
Somers, Gerald H.  
2506 Lower Huntington Rd. (8)  
Sparks, A. Jerome . Veterans Hosp.  
Stauffer, R. C.  
618 Medical Center Bldg. (2)  
Stellner, H. . . . . 324 W. Berry St.  
Stier, Paul L. . . . . 721 Broadway  
Stoler, A. E. . . . . 278 Central Bldg.

### ALLEN COUNTY (Fort Wayne—Continued)

Tennant, D. L. . . . 1832 S. Calhoun  
Terrill, R. W. . . . 455 Lincoln Tr. (2)  
Thimlar, J. W. . . . 602 E. Lewis (2)  
Thompson, H. . . . Irene Byron San.  
Thornton, Walter E.  
Lincoln Nat. Life Ins. Co.

Walker, Floyd B. . . . 610 E. Pontiac  
Warfield, C. H. . . . 730 W. Berry St.  
Weber, John R.

519 Wayne Phar. Bldg.  
Welty, S. G. 2702½ S. Calhoun (5)  
Wilkins, R. W. . . . 2902 Fairfield (6)  
Williams, A. B. 3526 N. Wash. Rd.  
Williams, A. H. . . . 2902 Fairfield (6)  
Wilson, Leslie . . . Veterans Hosp.  
Wilson, R. B. 1207 S. Lafayette (2)

Worley, Ansel C.  
317 Medical Center Bldg. (2)  
Wright, Wm. C.  
621 Medical Center Bldg. (2)

Wyatt, James L. III  
339 W. Berry St.

Wyatt, J. L. II 233 E. Jefferson (2)

X-Y-Z  
Zehr, Noah . . . 301 W. Creighton (6)  
Zweig, E. S. . . . 344 W. Berry (2)

Emme, Richard W. . . . Harlan  
Ponczek, Edward . . . Monroeville  
Dahling, C. W. . . . New Haven  
Emenhiser, Donald C. . . New Haven  
Hoetzer, Eldore A. . . . New Haven  
Smith, Grover M. . . . New Haven  
Smith, Richard B. . . . New Haven  
Stumpf, Edwin E. . . . New Haven  
Mosier, Edward (S)

Box 65, Woodburn  
DeVoe, Kenneth  
7314 N. St., S. W.,  
Tacoma, Wash.

Draper, Merlin H.  
R. 4, Box 695, Tampa, Fla.  
Ferguson, Arthur N.  
Veterans Hosp.,  
Little Rock, Ark.

Havice, Jay F.  
240 S. Hibiscus Dr.,  
Miami Beach 39, Fla.

Lloyd, Robert P.  
2350 Secone Rd., Secone, Pa.  
Miller, William J.  
Mayo Clinic, Rochester, Minn.

Smith, Roger C.  
Mayo Clinic, Rochester, Minn.

### BARTHOLOMEW-BROWN COUNTIES

Columbus

Adler, David L.  
Bartholomew County Hospital  
Beggs, Lowell F.

633 Washington St.  
Carpenter, Thomas D.

911 Washington St.  
Dagley, Hubert . . . 1103 California  
Davis, Marvin R.

814 Washington St.  
Fisher, Walter S. . . . 422 9th St.  
Hart, Robert B.

712 Washington St.  
Hawes, James K. (S)

725 Washington St.  
Hawes, Marvin E.

633 Washington St.

### BARTHOLOMEW-BROWN COUNTIES

(Columbus—Continued)

Henry, Alvin L. . . 621 Franklin St.  
Macy, George W.

718 Washington St.  
Marr, Griffith . . . 741 Washington St.  
Norton, Harold J.

633 Washington St.  
O'Bryan, Richard B. 326 16th St.  
Overshiner, Lyman

633 Washington St.  
Ritteman, George W.

Bartholomew County Hospital  
Rothing, Howard E.

Bartholomew County Hospital  
Ryan, William J.

641 Washington St.  
Schmitt, Richard K.

437½ Washington St.  
Sigmund, William B. 522 7th St.  
Teal, Dorothy Denzle

728 Franklin St.  
Williams, Everett W.

725 Washington St.  
Wissman, William L.

725 Washington St.  
Wood, Elmer U. (S)

2012 Washington St.  
Yoder, Dewey D.

725 Washington St.  
Zaring, Byron K.

718 Washington St.

Dudding, Joseph E. . . . Hope  
Schneider, Kenneth . . . Nashville

### BENTON COUNTY

Taylor, Wade H. . . . Ambia  
Atkinson, Charles W. . . . Boswell  
Leak, Robert . . . . . Boswell  
Coddens, A. L. . . . . Earl Park  
Altier, William H. . . . . Fowler  
Turley, Verne L. . . . . Fowler  
Smith, Charles G. . . . . Otterbein  
Scheurich, Virgil . . . . . Oxford

### BLACKFORD COUNTY

(See Delaware-Blackford)

### BOONE COUNTY

Riley, Frank H. (S) . . . Jamestown  
Schaaf, Alvin D. . . . . Jamestown  
Ballard, Robert J. . . . . Lebanon  
Beck, Herma A. . . . . Lebanon  
Coons, John D. . . . . Lebanon  
Coons, Ritchie . . . . . Lebanon  
Headley, Lloyd M. . . . . Lebanon  
Honan, Paul R. . . . . Lebanon  
Kern, Clarence G. . . . . Lebanon  
Porter, Jack . . . . . Lebanon  
Rainey, Everett A. . . . . Lebanon  
Spieth, William H. . . . . Lebanon  
Weddle, Charles O. . . . . Lebanon  
Wiseheart, Robert H. . . . Lebanon  
Bassett, Clancy . . . . . Thorntown  
Bassett, Margaret A. . . . Thorntown  
Gregg, Edwin E. . . . . Thorntown  
Bailey, Lawrence S. . . . . Zionsville  
Harvey, Ralph J. . . . . Zionsville  
Johns, Elmer . . . . . Zionsville  
Lovett, Harvey . . . . . Whitestown

### BROWN COUNTY

(See Bartholomew-Brown)

### CARROLL COUNTY

VanKirk, John R. . . . . Burlington  
Kennedy, Eva N. . . . . Camden  
Wise, Charles L. . . . . Camden  
Brown, Thomas . . . . . Delphi  
Byrne, John M. . . . . Delphi  
Crampton, Charles C. (S) . . Delphi  
Wagoner, George W. . . . . Delphi  
Wagoner, John B. . . . . Delphi  
Adams, Max R. . . . . Flora  
McLaughlin, James R. . . . . Flora

### CASS COUNTY

Dutchess, C. Toney . . . . Galveston

#### Logansport

Adamski, Michael . . . 408 North St.  
Bailey, Earl W. . . . . 212 Fifth St.  
Ballard, Chas. A. . . . 325½ E. Market  
Cooper, Thomas L. . . . 408 North St.  
Davis, John C. . . . . Masonic Temple  
Fitzgerald, Brice E.

Masonic Temple  
Hall, Bernard R. . . . 415 North St.  
Hedde, Eugene L. . . . 309 Seventh St.  
Hillis, Lowell J. . . . . 203 S. Third  
Hochhalter, M. . . . . 307 Barnes Bldg.  
Hogle, F. D. . . . . Logansport St. Hosp.  
Holloway, W. A. (S)

200 Eel River Ave.  
Holmes, W. W. . . . . Masonic Temple  
Jewell, Earl B. . . . . 3019 S. Penn St.  
Jones, J. Carl . . . . . 422 North St.  
Killian, E. Camille

211 S. Third St.  
Killian, Edgar W. . . . 211 S. Third St.  
Larson, John A. . . . . State Hosp.  
Lemon, H. K. . . . . State Hosp.  
Maxwell, John B. (S)

1119 High St.  
Morrical, Russell S. . . 212 Fifth St.  
Morrow, George W. . . . State Hosp.  
O'Leary, F. T. . . . . 94 Eel River Ave.  
Pfuetze, Max . . . . . State Hosp.  
Schenk, Foss . . . . . 97 21st St.  
Shultz, Henry M. (S)

412 Fourth St.  
Stanton, Jas. J. . . . . 220 S. Sixth St.  
Stewart, Milton B. (S)

308½ Fourth St.  
Terflinger, Fred W. (S)

422 North St.  
Viney, Charles L. . . . Masonic Temple  
Wilson, Paul H. . . . . 422 North St.  
Winter, Donald K. . . . 422 North St.

Newcomb, Wm. K. . . . Royal Center  
Flanagan, Estle P. . . . . Walton  
Lybrook, Daniel E. . . . Young America

### CLARK COUNTY

Bottorff, David . . . . . Charlestown  
Goodman, Eli . . . . . Charlestown  
Patterson, Cecil . . . . . Charlestown  
Willner, Alan . . . . . Clarksville  
Greene, William R. . . . . Henryville

#### Jeffersonville

Adair, Samuel L. 111 W. Court St.  
Baldwin, J. H. (S) . . 425 Meigs Ave.  
Bruner, Ralph W. . . . 437 Spring St.  
Buckley, Ernest P.

14 Blanche Terrace  
Carlberg, Dale . . . . 442 Spring St.  
Carney, Joel T. . . . . 344 Spring St.



**CLARK COUNTY**

(Jeffersonville—Continued)

Clark, William B., Jr.  
205 Lindley Bldg.  
Dare, Lee A. . . . . 209 E. Maple St.  
Forsee, Norman E. . . . . 456 Spring St.  
Huoni, John S. . . . . 105 W. Maple St.  
Isler, Nathaniel C. . . . . 521 Spring St.  
Reeder, Henry H. . . . . 140 High St.  
Varble, William M. (S) . . . . . Best Bldg.  
Weems, Mallory P. . . . . 404 Spring St.

Regan, George L. . . . . Sellersburg  
Sturgis, D. G. . . . . Sellersburg  
Vandervert, Arthur C. Sellersburg

**CLAY COUNTY**

Maurer, J. Frank . . . . . Brazil  
Maurer, Robert M. . . . . Brazil  
Palm, John M. . . . . Brazil  
Shattuck, John C. . . . . Brazil  
Sourwine, Clint C. . . . . Brazil  
Weaver, Timothy M. (S) . . . . . Brazil  
Webster, Robert K. . . . . Brazil  
Wood, Opal L. . . . . Brazil  
Moon, Charles E. . . . . Center Point  
Bond, Walter C. . . . . Clay City  
Glosson, Jack R. . . . . Clay City  
Ward, Harry H. (S) . . . . . Coalmont

**CLINTON COUNTY**

Waits, Chester L. . . . . Colfax

**Frankfort**

Applegate, A. E. . . . . 51 E. Walnut St.  
Beardsley, Frank A. . . . .  
51 S. Jackson St.  
Beardsley, John. . . . . 51 S. Jackson St.  
Burroughs, Carroll A. . . . .  
59 S. Main St.  
Carrel, Francis E. . . . .  
207½ N. Jackson St.  
Chittick, A. G. . . . . 206 E. Walnut St.  
Compton, Charles B. . . . .  
51 S. Jackson St.  
Dykhuizen, Theodore A. . . . .  
59 S. Main St.  
Erdel, Milton W. . . . . 59 S. Main St.  
Hammersley, Geo. K. . . . .  
361 E. Clinton St.  
Hedgcock, Robert A. . . . .  
205 E. Clinton St.  
Holmes, Claude, Sr. . . . . 9½ W. Clinton St.  
Jones, William W. . . . .  
9½ W. Clinton St.  
Kneidel John H. . . . .  
Clinton County Hospital  
Robison, Claude A. . . . . 508 S. Main St.  
Stout, Harry T., Jr. . . . .  
361 E. Clinton St.  
Van Kirk, John A. . . . .  
204 W. Washington St.  
Van Kirk, Paul P. . . . .  
204 W. Washington St.

Work, Bruce A. . . . . 47½ S. Jackson St.  
Carlyle, Ivan E. . . . . Michigantown  
Combs, Nelson B. . . . . Mulberry  
Kent, John A. . . . . Mulberry  
Grove, Robert H. . . . . Rossville  
Ketcham, John S. . . . . Rossville

**CRAWFORD COUNTY**

(See Harrison-Crawford)

**DAVISS-MARTIN  
COUNTIES**

Pfrommer, John. . . . . Crane  
Rohrer, James R. . . . . Elnora

Chattin, Robert E. . . . . Loogootee  
Lett, Emory B. . . . . Loogootee  
McCracken, Jacob O. . . . . Montgomery  
Sears, Don . . . . . Odon  
Coleman, H. G. . . . . Odon  
Gilkison, John S. . . . . Shoals  
Gilkison, William L. (S) . . . . . Shoals  
Maschmeyer, Robert H. . . . . Shoals  
Arthur, Nora M. . . . . Washington  
Blazey, Arthur G. . . . . Washington  
Burruss, Bert O. (S) . . . . . Washington  
Chattin, Vance J. . . . . Washington  
Farris, John J. . . . . Washington  
Fox, C. Philip . . . . . Washington  
Lindsay, Hamlin B. . . . . Washington  
Lloyd, Claude A. . . . . Washington  
McKittrick, Jack . . . . . Washington  
McNaughton, L. M. . . . . Washington  
Norton, Horace . . . . . Washington  
Rang, Arthur A. . . . . Washington  
Rang, Robert H. . . . . Washington  
Schafer, Wm. C. . . . . Washington  
Schroeder, Henry . . . . . Washington  
Shields, Harry A. . . . . Washington  
Smoot, Emory B. . . . . Washington

**DEARBORN-OHIO  
COUNTIES**

Baker, Leslie M. . . . . Aurora  
Jackson, John K. . . . . Aurora  
Olcott, Charles W. . . . . Aurora  
Stewart, Omer H. . . . . Aurora  
Treon, James F. . . . . Aurora  
McNeely, Matthew J. . . . . Dillsboro  
Elliott, John C. . . . . Guilford  
Fagaly, William J. . . . . Lawrenceburg  
Houston, Fred D. . . . . Lawrenceburg  
Pfeifer, James M. . . . . Lawrenceburg  
Streck, Francis A. . . . . Lawrenceburg  
Vail, George A. . . . . Lawrenceburg  
Fessler, Gordon S. . . . . Rising Sun  
Manley, Charles N. . . . . Rising Sun

**DECATUR COUNTY**

Tremain, Milton A. (S) . . . . . Adams  
Acher, Robert P. . . . . Greensburg  
Blemker, Russell H. . . . . Greensburg  
Callaghan, Winship C. . . . . Greensburg  
Dickson, Dale D. . . . . Greensburg  
McKee, Harley S. . . . . Greensburg  
Miller, James C. . . . . Greensburg  
Morrison, James T. . . . . Greensburg  
Mullikin, Clarence W. . . . . Greensburg  
Overpeck, Charles . . . . . Greensburg  
Sallee, William T. . . . . Greensburg  
Harkcom, Harry E. . . . . St. Paul  
Porter, Edward A. . . . . Westport

**DEKALB COUNTY**

Thill, Leonard S. . . . . Ashley  
Covell, Harry M. . . . . Auburn  
Geisinger, Lewis N. (S) . . . . . Auburn  
Hines, Archie V. . . . . Auburn  
Hippensteel, Harland V. . . . . Auburn  
Nugen, Harold . . . . . Auburn  
Rogers, Evered E. . . . . Auburn  
Sanders, Jesse A. . . . . Auburn  
Souder, Bonnell M. . . . . Auburn  
Wills, Max . . . . . Auburn  
Hathaway, Clayton B. . . . . Butler  
Weirich, Charles I. . . . . Butler  
Jinnings, Loren E. . . . . Garrett  
Kantzer, Floyd B. . . . . Garrett  
Nason, Robert A. . . . . Garrett

Reynolds, D. Monroe (S) . . . . . Garrett  
Reynolds, Russell P. . . . . Garrett  
Coleman, Floyd B. . . . . Waterloo  
Showalter, John P. . . . . Waterloo  
Mettler, Don C. . . . .

Lowry Field, Denver, Colo.  
Van Nest, Willard A.  
New Smyrna Beach, Fla.

**DELAWARE-BLACKFORD  
COUNTIES**

Brown, Stewart D. . . . . Albany  
Puterbaugh, Karl E. . . . . Albany  
Hurley, John R. . . . . Daleville  
Tucker, Oral A. . . . . Daleville  
Ko, Richard . . . . . Eaton  
Downard, Leland F. . . . . Gaston  
Langsdon, Fred R. . . . . Gaston  
Dando, G. H. (S) . . . . . Hartford City  
Dodds, Jas. U. . . . . Hartford City  
Jackson, Dean B. . . . . Hartford City  
Owsley, C. E. M. . . . . Hartford City  
Owsley, Guy A. . . . . Hartford City  
Parks, George . . . . . Hartford City  
Weldy, Bryce P. . . . . Hartford City  
Werry, Leslie E. . . . . Hartford City  
Wierzalis, Edward F. . . . . Hartford City

Burns, Paul E. . . . . Montpelier  
Douglas, William T. . . . . Montpelier  
Taylor, James A. (S) . . . . . Montpelier

**Muncie**

Adams, W. B. . . . . Ball Mem. Hosp.  
Alvey, C. R. . . . .  
402 W. Washington St.  
Ball, Clay A. . . . . 303 W. Adams  
Ball, Phillip . . . . .  
420 W. Washington St.  
Bibler, Henry E. . . . . 311 W. Adams  
Botkin, C. G. . . . . 508 W. Jackson  
Botkin, Thos. . . . . 1625½ University  
Brown, Leland G. . . . .  
206 S. High St.

Brown, Thomas M. . . . .  
206 S. High St.

Brunoehler, Carl J. . . . .  
110 N. Cherry St.

Burwell, Stanley W. . . . .  
424 W. Jackson St.

Butterfield, R. M. . . . . 315 W. Jackson  
Clauser, E. H. M. . . . . 315 S. Jefferson  
Clevenger, J. H. . . . . 424 W. Jackson  
Cole, R. E. . . . . 203 West. Res. Bldg.  
Covalt, W. E. . . . . 305 West. Res. Bldg.  
Cure, E. T. . . . . 105 West. Res. Bldg.  
Davis, Edgar C. . . . . 107 Plaza Bldg.  
Deutsch, Wm. . . . . 309 Johnson Bldg.  
Dunn, F. W. . . . . 118 S. Franklin  
Egbert, Clarence H. . . . . 2010 S. Vine  
Fitch, Ray T. . . . . 1708 W. Jackson  
Funk, John W. . . . . 217 W. Charles  
Galliher, M. J. . . . . 115 S. Liberty  
Garling, L. C. . . . . 420 W. Washington  
Geckler, Charles E. . . . .

**Muncie Clinical Lab.**

Gill, Thos. A. . . . . 808 W. Jackson  
Greiber, M. F. . . . . 420 W. Washington  
Gustafson, Milton. . . . . 808 W. Jackson  
Hall, Orville A. . . . . 514 Wysor Bldg.  
Hayes, T. R. . . . . 210 S. High  
Henderson, R. A. . . . . 806 W. Main  
High, Ralph L. . . . . 420 W. Washington  
Hill, Howard E. . . . . 402 W. Jackson  
Hill, Robert E. . . . . 215 W. Jackson  
Hostetter, Irwin S. . . . . 115 N. Cherry  
Hurley, Anson G. . . . . 110 N. Cherry



# DELAWARE-BLACKFORD COUNTIES

## (Muncie—Continued)

Imhof, Jos. D. 206 West. Res. Bldg.  
Kammer, G. C. 420 W. Washington  
Kammer, W. F. 420 W. Washington  
Kemper, A. T. (S) 112 W. Adams  
Kern, C. B. (S) 715 E. Washington  
Kirshman, F. E. 211 S. High  
Kuder, Howard V.

420 W. Washington  
LaDuron, J. F. 517 S. Liberty  
McClintock, James A.

316 W. Adams  
McCoy, George E. 417 Wysor Bldg.  
McDowell, Fletcher W.

315 S. Jefferson  
McMichael, R. M. 324 W. Adams  
Molloy, W. J. (S) 310 W. Jackson  
Montgomery, Lall G.

Ball Memorial Hospital  
Moore, Thos. C. 110 N. Cherry  
Moore, Wm. C. 110 N. Cherry  
Morris, Jean W. 247 Johnson Bldg.  
Nelson, Harold E.

Ball Memorial Hospital  
Owens, R. R. 406 West. Res. Bldg.  
Owens, T. R. 202 West. Res. Bldg.  
Peacock, Robert C.

205 West. Res. Bldg.  
Quick, Wm. J. 314 E. Washington  
Rettig, Arthur C. 314 W. Jackson  
Rivers, Glynn A. 806 W. Jackson  
Schulhof, M. G. 418 W. Wash.  
Smith, Jas. S. 501 Kirby  
Spurgeon, O. E. 310 E. Washington  
Stanley, John R.

410 W. Jackson St.  
Starks, William O.

507 Alameda Ave.  
Stocking, B. W. Ball Mem. Hosp.  
Tindal, E. F. (S) 214 Wysor Bldg.  
Tomlin, Hugh M.

420 W. Washington  
Turner, Robt. D. 217 S. Liberty  
Venis, K. N. 108 N. Liberty  
Vlaskamp, E. M. 401 W. Main  
Williams, J. H. 306 E. Jackson  
Wood, Amelia T. 2004 Petty Rd.  
Young, G. S. 316 W. Jackson

Craigmile, Thomas K. Oakville  
Moss, Mavor J. Yorktown  
Mahuron, Boyd L.

Miami Valley Hospital,  
Dayton 9, Ohio

# DUBOIS COUNTY

Backer, Henry G. Ferdinand  
Amini, Sohrab Huntingburg  
Bretz, John M. Huntingburg  
Lukemeyer, L. C. (S)

Huntingburg  
Stork, Harvey K. Huntingburg  
Williams, F. P. Huntingburg  
Blessinger, Paul J. Jasper  
Greenburg, Rolland Jasper  
Heck, Martin C. Jasper  
Held, George A. Jasper  
Klamer, Charles H. Jasper  
Lukemeyer, George T. Jasper  
Lukemeyer, St. John Jasper  
Salb, Leo A. Jasper  
Wagner, Arthur L. Jasper

# ELKHART COUNTY

Horswell, Richard G. Bristol  
Neidballa, Edward G. Bristol

# ELKHART COUNTY

## (Continued)

### Elkhart

Arlook, Theo. D. 912 W. Franklin  
Bender, Robt. L. 411 S. Third  
Billings, Elmer R. 115 S. Third St.  
Bloom, Geo. R. 506 S. Second  
Bolin, Robt. S. 209 S. Second  
Bowdoin, Geo. E. 515 S. Second  
Compton, W. A. 2225 Greenleaf  
Conklin, R. L. 1906 E. Jackson  
Cormican, H. L. 316 S. Fourth  
Crandall, L. A. Ames Laboratories  
DeDario, L. M. 123 W. Marion  
Dewey Fred N. (S) 127 N. Fifth  
Elliott, Lloyd A. 405 S. Second  
Elliott, Thomas A.

405 S. Second St.  
Fleming, C. F. 121 W. Marion  
Fleming, Justus M. 123 W. Marion  
Hull, Arthur W. 506 S. Second  
Kintner, B. E. 132 Monger Bldg.  
Kistner, A. W. 123 W. Marion  
Koehler, Elmer G. Monger Bldg.  
Logan, Richard S. Monger Bldg.  
Lundt, Milo O. 519 S. Second  
Markel, Ivan J. 215 W. Franklin  
McKee, H. N. (S)

319 Monger Bldg.  
Mendez, Carlos 116 W. Marion  
Miller, Galen R.

903 W. Franklin St.  
Miller, H. A., Jr. 314 W. Jackson  
Miller, Samuel T. 506 S. Second  
Mininger, E. P. 413 W. Franklin  
Mishkin, Irving 209 S. Second  
Norris, Allen A. (S)

208 W. Marion  
Paff, Wm. A. 515 S. Second  
Paine, Geo. E. 419 Modrell  
Pancost, V. K. 415 S. Second  
Patrick, Glenn B. 427 S. Second  
Possolt, Thos. R. 208 Equity Bldg.  
Rohr, Joseph H.

Ames Laboratories  
Rupe, Lloyd O. Equity Bldg.  
Schlosser, H. C. 116 W. Marion  
Sears, M. M. (S) 304 Equity Bldg.  
Spray, Page E. 405 S. Second  
Stauffer, W. A. (S)

214 Equity Bldg.  
Stout, R. B. 1501 Greenleaf Blvd.  
Stubbins, Wm. M. 412 S. Second  
Swank, L. F. 315 Equity Bldg.  
Swihart, H. R. 417 N. 2nd St.  
Swihart, L. F. 214 W. Marion  
Todd, David D.

2001 E. Jackson Blvd.  
Wilson, O. E. 217 N. Main  
Work, Jas. A., Jr. 412 S. Second  
Yoder, C. Richard

427 S. Second St.

### Goshen

Amstutz, H. C. 521 S. Main  
Bartholomew, M. L. 107 S. Fifth  
Bender, C. K. 115 E. Washington  
Bigler, Frederick W.

307 S. Seventh

Bosler, Howard A.  
Waterford Mills, Mail Goshen  
Eby, Ida L. 131 S. Main  
Freeman, F. M. 109 W. Wash.  
Hostetler, C. M. 304 E. Lincoln  
Kelly, Wm. R. 210 N. Main  
Kinzie, M. Dale. Shoots Bldg.

Martin, Floyd S. 127 E. Lincoln  
Miller, M. E. Spohn Bldg.  
Simmons, L. H. 208 E. Lincoln  
Turner, John P. Shoots Bldg.  
Westfall, Geo. S. 214 E. Lincoln  
Yoder, Albert C. 113 S. Fifth  
Young, Ralph H. 113 E. Madison

Norris, Ernest B. Middlebury  
Teters, Melvin S. Middlebury  
Chandler, Leon H. Millersburg  
Fleetwood, R. A. Nappanee  
Kendall, Forest M. Nappanee  
Price, Douglas W. Nappanee  
Slabaugh, Jancey S. (S) Nappanee  
Roose, Lisle W. Nappanee  
De Fries, John. New Paris  
Stuckman, E. D. (S) New Paris  
Abel, Robert. Wakarusa  
Amick, Charles L. Wakarusa  
Hannah, Jack W. Wakarusa

# FAYETTE-FRANKLIN COUNTIES

Foreman, Walter A. Brookville  
Peters, Elmer Brookville  
Seal, Perry F. Brookville  
Smith, Herbert N. Brookville

## Connersville

Cavitt, Robert F. 930 Central  
Dale, Maxwell H. 818 Grand  
Ellis, Geo. M., Jr. 108 E. Tenth  
Entner, Charles L. 117 E. Sixth  
Fruth, Rodney B. 634 Eastern  
Fruth, Virgil J. 634 Eastern  
Gordin, Stanley B. R. D. 3  
Gregg, Albert F. 124 E. Sixth  
Hoeger, H. R. 523½ Central  
Kemp, William A. 122 W. Seventh  
Lockhart, Jack M. 520 Eastern  
Mountain, Francis B. 930 Central  
Neukamp, Frank H.

American Central Mfg. Co.  
Smelser, Herman W. 823 Central  
Watterson, Gerald T.  
1910 Virginia Ave.

Phillips, William R. Glenwood  
Daley, Edward H. Oldenburg

# FLOYD COUNTY

Engleman, Harry K. Georgetown

## New Albany

Allen, Frederick K.  
1207 E. Spring St.  
Baker, Avey M. 811 E. Spring  
Baxter, Jas. W. 1201 E. Spring  
Baxter, Saml. M. 1201 E. Spring  
Briscoe, C. E. (S) 1413 E. Spring  
Brown, Kenneth H. 410 E. Spring  
Byrn, Howard W. 416 Elsby Bldg.  
Cannon, Daniel H. 216 Elsby Bldg.  
Davis, Parvin M. 601 E. Spring  
Day, George H. 1252 Vincennes  
Edwards, William F.

Floyd County Bank Bldg.  
Garner, Wm. H. 919 E. Spring  
Gentile, John P. 1313 E. Spring  
Hauss, A. P. 212 Elsby Bldg.



**FLOYD COUNTY**

(New Albany—Continued)

Hess, Paul P.  
Floyd Co. Bank Bldg.  
Higgins, John R.  
624 E. Spring St.  
LaFollette, Robt. E....500 Spring  
McCullough, J. Y....624 E. Spring  
Murphy, Edgar W....1824 State  
Pace, Jerome V....Silvercrest San.  
Paris, John M....602 E. Spring  
Pierce, Gene S....R. R. 21  
Pierson, Percy R.  
203 Liberty State Bank Bldg.  
Polhemus, G. I....1610 E. Spring  
Robertson, A. N....820 E. Spring  
Shacklett, Henry B. (S)  
117 E. Spring St.  
Sloan, Herbert....1207 E. Spring  
Streepey, J. I....1102 E. Spring  
Tyler, Frank T....420 Vincennes  
Voyles, Harry E....216 Elsy Bldg.  
Weaver, Wm. W....1104 E. Spring  
Witt, William R....908 E. Spring St.  
Wohlfeld, Gerald.Silvercrest San.  
Wolfe, Nelson....1117 E. Spring

**FOUNTAIN-WARREN  
COUNTIES**

Fisher, John E.....Attica  
Freed, Carl A.....Attica  
Freed, James C.....Attica  
Maris, Lee J.....Attica  
Johnson, Earl E.....Covington  
Stephens, Lowell R....Covington  
Suzuki, T. T.....Covington  
Priebe, Fred H.....Hillsboro  
Smith, Byron J.....Kingman  
Himebaugh, G. J....Veedersburg  
McCord, Carl B....Veedersburg  
Lefforge, E. Everett..Veedersburg  
Rusk, Hubert M.....Wallace  
Nelson, Carl A....West Lebanon  
Crain, James W....Williamsport  
Schmiedicke, P. H....Williamsport

**FULTON COUNTY**

Herrick, Charles L.....Akron  
Miller, Virgil.....Akron  
Dielman, Franklin C.....Fulton  
Kelsey, Lawrence E....Kewanna  
Kraning, Kenneth K....Kewanna  
Glackman, John C....Rochester  
Herendeen, Elbie V....Rochester  
Knotts, Slater.....Rochester  
Richardson, Chas. L....Rochester  
Rowe, Howard H....Rochester  
Stinson, Arthur E....Rochester  
Stinson, Dean K....Rochester

**GIBSON COUNTY**

Geick, Raymond G....Fort Branch  
Hollis, Walter.....Fort Branch  
Marchand, Austin F....Haubstadt  
Marchand, Edwin V....Haubstadt  
Pettijean, Harold G....Haubstadt  
Arthur, Hamilton M. (S) Hazelton  
Chappell, Harold R.  
Oakland City  
Ropp, Eldon R....Oakland City  
Turner, Maurice....Oakland City  
Wood, Russell W....Oakland City  
Geller, Samuel.....Owensville

Montgomery, James R...Owensville  
Strickland, Karl S....Owensville  
Alexander, Harry H....Princeton  
Brazelton, O. T.....Princeton  
Carpentier, Harry F....Princeton  
Folck, John K.....Princeton  
Graves, Orville M....Princeton  
Hollingsworth, M. P. (S) Princeton  
McCarty, Virgil.....Princeton  
McElroy, Robert S....Princeton  
Miller, Charles A. (S) Princeton  
Morris, W. F. (S)....Princeton  
Peck, James F.....Princeton  
Rhodes, Amos H....Princeton  
Weitzel, Roland.....Princeton

**GRANT COUNTY**

Grant, M. Arthur.....Fairmount  
Henley, Glenn (S)....Fairmount  
King, Dale S.....Fairmount  
Garrison, Leon J.....Gas City  
Koontz, William A.....Gas City  
Baskett, Russell J....Jonesboro

**Marion**

Abell, Chas. F.  
321 Marion Natl. Bk. Bldg.  
Alderfer, Henry  
516 Marion Natl. Bank Bldg.  
Ayres, Wendell W....302 Glass Blk.  
Bates, George.....Davis Clinic  
Bloom, Asa W....724 W. Third  
Boyer, Grace M. 313 Iroquois Bldg.  
Braunlin, Robert F.  
718 Marion Nat. Bank Bldg.  
Braunlin, William H.  
718 Marion Nat. Bank Bldg.  
Brown, Robert M.  
522 Marion Nat. Bank Bldg.  
Burge, A. D. (S)  
204 Odd Fellows Bldg.  
Comeau, Wm. J.  
Marion General Hospital  
Currie, Robert W...Veterans Hosp.  
Daniels, Erle O.  
708 Marion Nat. Bank Bldg.  
Daniels, Geo. R....324 Glass Blk.  
Davis, Joseph B....Davis Clinic  
Davis, Merrill S....Davis Clinic  
Davis, Richard.....Davis Clinic  
Diamond, Leo L.  
413 Marion Nat. Bank Bldg.  
Eshleman, L. H. (S) 2927 S. Wash.  
Ferguson, John T.  
2219½ S. Washington St.  
Fisher, Henry.....1502 S. Wash.  
Ganz, Max.....930 S. Adams  
Ginsberg, S. T....Veterans Hosp.  
Gustafson, Carl J.  
Veterans Hospital

Huff, Asher D.....310 Glass Blk.  
Hummel, Russel M.  
317 Marion Nat. Bank Bldg.  
Lavengood, R. W....511 Glass Blk.  
Long, Max R.....803 S. Boots  
McIlwain, Eleanor E...107 E. 31st  
McIlwain, Robt. E....107 E. 31st  
Miller, H. Allison...321 Glass Blk.  
Powell, J. Paxton...309 Glass Blk.  
Renbarger, L. L....1531 W. Second  
Rhorer, John G.....201 S. D St.  
Simmons, Fredk. H.  
520 Whites Ave.  
Skomp, C. E....Marion Gen. Hosp.  
Warren, Carroll B.  
313 S. Nebraska

Weinberg, Samuel...318 Glass Blk.  
Wicker, Eugene H.  
Marion General Hospital  
Wiersma, Alvin F....Davis Clinic  
Young, Robt. G.....2927 S. Wash.

King, Peter C.....Swayzee  
Taylor, Everett C....Upland  
Rifner, E. S.....Van Buren

**GREENE COUNTY**

Graf, Jerome A.....Bloomfield  
Mount, Mathias S....Bloomfield  
Turner, Harold B....Bloomfield  
Turner, Jack J.....Bloomfield  
Van Sandt, Frank A. (S) Bloomfield

Porter, Carl M.....Jasonville  
Rotman, Harry G....Jasonville  
Rotman, Sam I.....Jasonville  
Bailey, Edwin B....Linton  
Broshears, Kenneth...Linton  
Craft, William F....Linton  
Porter, George C. (S) Linton  
Raney, Ben B.....Linton  
Tomak, Milton E....Linton  
Woner, John W.....Linton  
Manzie, Michael W....Lyons  
Hamilton, M. Luther...Newberry  
Fender, Asa H.....Worthington  
Moses, George E....Worthington  
Moses, Robert E....Worthington

**HAMILTON COUNTY**

Hicks, Joseph (S)....Arcadia  
Rodenbeck, Frank....Arcadia  
McDaniel, Franklin P...Atlanta  
Donahue, Claude M....Carmel  
Havens, Oscar.....Cicero  
Tomlinson, C. H. (S) Cicero  
Ambrose, Jesse C....Noblesville  
Campbell, Sam W....Noblesville  
Harris, Robert F....Noblesville  
Hash, John S.....Noblesville  
Hooke, Samuel W....Noblesville  
Kraft, Haldon C....Noblesville  
Shanks, Ray.....Noblesville  
Shonk, Harold W....Noblesville  
Southard, Carl B....Noblesville  
Thayer, Jos. O...R.R. 1, Noblesville  
Griffith, James W....Sheridan  
Newby, Alonzo C....Sheridan  
Newby, Eugene.....Sheridan  
Reck, John L.....Sheridan  
Young, Edward M. (S) Sheridan  
Connoy, Andrew F....Westfield  
Connoy, Leo F.....Westfield

**HANCOCK COUNTY**

Scott, Robert S....Charlottesvile  
Ferrell, Jesse E.....Fortville  
Ferrell, Mars B.....Fortville  
Manifold, Harold M....Fortville  
Navin, Hugh K.....Fortville  
Allen, Joseph L. (S) Greenfield  
Endicott, Wayne.....Greenfield  
Gibbs, Charles M. (S) Greenfield  
Gill, Dee D.....Greenfield  
Henn, R. Anthony....Greenfield  
Hunter, Donn.....Greenfield  
Kinneman, Robert E...Greenfield  
Vingus, Bronie.....Greenfield  
Woods, James R., Jr...Greenfield  
Pierson, Thos. A....New Palestine  
Kuhn, Robert W....Wilkinson  
Titus, Charles R. (S) Wilkinson



## HARRISON-CRAWFORD COUNTY

Amy, William E. . . . . Corydon  
 Blessinger, Louis H. . . . . Corydon  
 Brockman, Wilfred . . . . . Corydon  
 Dillman, Carl E. . . . . Corydon  
 Baker, Guy D. . . . . Crandall  
 Gobel, N. E. . . . . English  
 Benz, Jesse . . . . . Marengo  
 Lynch, O. R. . . . . Marengo  
 Mathys, Alfred . . . . . Mauckport  
 Johnson, J. J. (S) . . . . . Milltown  
 Neely, Alonzo S. . . . . New Middletown  
 Johnson, J. M. . . . . Palmyra  
 Glenn, Lafayette (S) . . . . Ramsey

## HENDRICKS COUNTY

Foltz, Lloyd E. . . . . Brownsburg  
 Scudder, Arthur N. . . . . Brownsburg  
 Ellett, John, Jr. . . . . Coatesville  
 Elliott, Paul W. . . . . Danville  
 Frantz, Mount E. . . . . Danville  
 Koch, Elmer L. . . . . Danville  
 Price, Ernest H. . . . . Danville  
 Terry, Lloyd . . . . . Danville  
 Ellis, Lyman H. . . . . Lizton  
 Wischeart, O. H. (S) . . . . North Salem  
 Scamahorn, Malcolm O. . . . Pittsboro  
 Scamahorn, Oscar T. . . . Pittsboro  
 Aiken, Milo M. . . . . Plainfield  
 Cohen, Irving . . . . . Plainfield  
 Johnston, Alan . . . . . Plainfield  
 Stafford, James C. . . . . Plainfield  
 Walker, Jack . . . . . Plainfield

## HENRY COUNTY

Call, Earle B. . . . . Knightstown  
 Dreyer, Ralph W. . . . . Knightstown  
 Matychowiak, Francis . . . . Knightstown  
 Scheetz, Marion R. . . . . Lewisville  
 Dragoo, Farrol . . . . . Middletown  
 Hammer, Jay W. . . . . Middletown  
 Stauffer, George E. . . . . Mooreland  
 Marshall, Lloyd C. . . . . Mt. Summit

### New Castle

Amos, Robert L. . . . . 213 Burr Bldg.  
 Bitler, Clyde C. . . . . 1319 Church  
 Bledsoe, James G. . . . . 319 S. 14th  
 Burnett, Arthur B. . . . 310 Burr Bldg.  
 Canaday, Clifford E. (S) . . . 1411 Church  
 Craig, Alexander F. R. F. D. No. 2  
 Davies, Robert . . . . 1319 Church St.  
 Fincher, Robert C. . . . Ind. Village for Epileptics  
 Fisher, John E. . . . . 409 Burr Bldg.  
 Foster, Ray T. . . . . Chrysler Corp.  
 Harrison, B. L. . . . . 118 Jennings Bldg.  
 Heilman, William C. . . . 1319 Church  
 Hill, Kenneth G. . . . . 1319 Church  
 Itermann, George E. . . . 1319 Church  
 Kennedy, Walter U. . . . . 214 S. 14th  
 Life, Homer L. . . . . 101 S. 11th St.  
 McDonald, Frank C. . . . 106 N. Main  
 McElroy, James S. . . . . 1319 Church  
 Poston, Clement L. . . . . 209 Bradbury Bldg.  
 Saint, William . . . . 1319 Church St.  
 Smith, Robert A. . . . . 1229 Lincoln Ave.  
 Stout, Walter M. . . . . 1319 Church  
 Thorne, Charles E. . . . . 200 N. 12th  
 Tully, John A. (S) . . . . 502 S. Main

Van Nuys, W. C. (S) . . . Ind. Village for Epileptics  
 Vivian, Donald E. . . . Henry County Hospital  
 Wiggins, Dulanis S. (S) . . 1222½ Race

Wilson, Ralph (S) . . . . Shirley  
 Robertson, William S. . . . Spiceland  
 Roberts, Floyd N. . . . 535 W. Bennidge Lane,  
 Phoenix, Ariz.

## HOWARD COUNTY

Denton, Larkin D. . . . . Greentown  
 Shoup, Homer B. . . . . Greentown

### Kokomo

Adams, Charles J. . . . . 618 Armstrong Landon Bldg.  
 Alward, John H. . . . . 401 W. Walnut St.  
 Ault, Carl H. . . . . 421 W. North St.  
 Boughman, Joe D. . . . 322 Armstrong-Landon Bldg.  
 Bowers, C. C. . . . . 210 W. Mulberry  
 Bowers, Garvey B. . . . 210 W. Mulberry  
 Bowers, John A. . . . . 210 W. Mulberry  
 Bruegge, Theodore J. . . . 630 Armstrong-Landon Bldg.  
 Clarke, Elton R. . . . . 521 N. Main  
 Conley, Thomas M. . . . 520 Union Bank Bldg.  
 Craig, Reuben A. . . . . 608 Armstrong-Landon Bldg.  
 Craig, Reuben . . . . . 610 Armstrong-Landon Bldg.  
 Crawford, Theo. R. . . . 416 W. Sycamore  
 Cuthbert, Fredk. S. (S) . . 211 E. Jefferson  
 Earl, Max M. . . . . 409 W. Taylor  
 Ferry, P. W. . . . . 406 Union Bk. Bldg.  
 Golper, Marvin N. . . . . St. Joseph Mem. Hosp.  
 Good, Richard P. . . . . 308 Armstrong-Landon Bldg.  
 Halfast, Richd. W. . . . 214 E. Mulberry  
 Hutto, William H. . . . 408 Armstrong-Landon Bldg.  
 Jewell, George M. . . . . 508 Armstrong-Landon Bldg.  
 Knepple, LaMarr R. (S) . . 325½ N. Main  
 Kratzer, Eugene F. (S) . . . 320 W. Walnut  
 Lung, Bruce D. . . . . 410 Union Bk. Bldg.  
 McIndoo, Ralph E. . . . 304 W. Walnut  
 Meiner, Joseph A. . . . . 911 S. Main  
 Morrison, William R. . . . 504 Union Bank Bldg.  
 Murray, Ernest C. . . . 2200 S. Webster St.  
 Paris, Durward W. . . . 614 Armstrong-Landon Bldg.  
 Phares, Robt. W. . . . . 905 W. Mulberry  
 Ramey, John W. . . . . 107½ S. Union  
 Rhorer, Herbt. M. . . . 210 W. Mulberry  
 Rudicel, Max . . . . 1700 S. Washington  
 Schuler, Russell P. . . . 200½ N. Main  
 Schwartz, Frederick C. . . 518 Armstrong-Landon Bldg.  
 Scott, Russell F. . . . . Union Bk. Bldg.  
 Shenk, Earl M. . . . . 208½ N. Main  
 Smith, Gloster J. . . . 105½ E. Sycamore

Sorenson, Raymond . . . 522 Armstrong-Landon Bldg.  
 Spangler, Jesse S. . . . 215 E. Taylor

Evans, Robert M. . . . . Russiaville  
 Morford, Guy . . . . 2001 Winston Dr., Owensboro, Ky.

## HUNTINGTON COUNTY

### Huntington

Brubaker, Harold S. . . . 42 W. Park Dr.  
 Casey, Stanley M. . . . 408 E. Market  
 Clunie, Wm. A. . . . . 502 N. Jefferson  
 Cope, Stanton E. . . . 1022 N. Jefferson  
 Erehart, Mark G. . . . 232 W. Market  
 Eviston, John B. . . . . 34 E. Wash.  
 Galbreath, Russell S. . . 16 W. Wash.  
 Gray, Paul M. . . . . 340 E. Market  
 Grayston, W. S. . . . . 303 E. Market  
 James, Thomas, Jr. . . . 48 E. Franklin  
 Johnston, Robt. G. . . . 339 E. Market  
 Marks, Howard H. . . . 248 W. Park  
 Meiser, Robt. D. . . . . 612 N. Jefferson  
 Mitman, Floyd B. . . . 210 W. Park  
 Nie, Grover M. . . . . 220 W. Park Dr.  
 Omstead, T. W. . . . 244 E. Washington  
 Ware, James R. . . . . 48 E. Franklin

Woods, Halden C. . . . . Markle  
 Bigelow, Oliver P. . . . . Roanoke  
 Bennett, J. B. . . . . Warren  
 Black, C. S. . . . . Warren  
 Smith, Lucian . . . . . Warren

## JACKSON COUNTY

Cummings, David J. . . . Brownstown  
 Gillespie, Garland R. . . . Brownstown  
 Shields, Jack E. . . . . Brownstown  
 Adair, William K. . . . Crothersville  
 Bard, Frank B. . . . . Crothersville  
 Conner, Thos. E. (S) . . . Freetown  
 Black, Joe M. . . . . Seymour  
 Day, William D. C. . . . Seymour  
 Elsner, Lawrence W. . . . Seymour  
 Gillespie, Charles E. (S) . . Seymour  
 Graessle, Harold P. . . . Seymour  
 Kamman, Geo. H. (S) . . . Seymour  
 Martin, Guy . . . . . Seymour  
 Miller, Harold E. . . . . Seymour  
 Osterman, Louis H. . . . Seymour  
 Ripley, John W. . . . . Seymour  
 Shortridge, Wilbur H. . . . Seymour  
 Wiethoff, Clifford A. . . . Seymour

## JASPER-NEWTON COUNTIES

Pippenger, Wayne G. . . . Brook  
 Ockermann, Kenneth R. . . DeMotte  
 Smith, Marsh H. . . . . Goodland  
 Mathews, Wilbur C. . . . Kentland  
 VanKirk, George H. . . . Kentland  
 Yegerlehner, Roscoe S. . . Kentland  
 Larrison, Glenn D. . . . . Morocco  
 MacLeod, Donald F. . . . Morocco  
 Williams, H. J. . . . . Morocco  
 Schantz, Richard . . . . Remington  
 Sink, Frank G. . . . . Remington  
 Beaver, Ernest . . . . . Rensselaer  
 Johnson, Cecil E. . . . . Rensselaer  
 Kresler, Leon . . . . . Rensselaer



O'Neill, Martin ..... Rensselaer  
Gwin, Merle D. .... 2111 Regatta Ave.,  
Miami Beach, Fla.

## JAY COUNTY

Garber, Edwin C. .... Dunkirk  
Hall, Emory H. .... Dunkirk  
Heller, Nelson L. R. .... Dunkirk  
Shroyer, Herbert ..... Dunkirk  
Hiestand, Harley J. .... Pennville  
Badders, Ara C. .... Portland  
Cring, George V. .... Portland  
Cripe, William ..... Portland  
Engle, John M. .... Portland  
Fitzpatrick, James ..... Portland  
Hammond, Stanley M. .... Portland  
Keeling, Forrest E. .... Portland  
Lyon, Florence ..... Portland  
Moran, Mark M. .... Portland  
Schwartz, Wm. D. (S) .... Portland  
Spahr, Donald E. .... Portland  
Steffy, Ralph ..... Portland  
Lansford, John ..... Redkey  
Kidder, John J. (S) .... Salamonia

## JEFFERSON-SWITZERLAND COUNTY

Robertson, David W. (S) .... Deputy  
Henning, Carl ..... Hanover

### Madison

Alcorn, Merritt O., Jr. ....  
428 E. Main St.  
Beetem, Luther F. .... 425 W. Main  
Childs, A. G. W. (S) .... 412 E. Main  
Childs, Wallace E. .... 420 Elm  
Denny, Fred C. .... Odd Fellows Bldg.  
Hamilton, Guy W. (S) ..... Clifty Hotel  
Jolly, Lewis E. .... Madison Clinic  
May, George A. .... 426 E. Main  
Modisett, Jackson W. .... Madison Clinic

Modisett, Marcella S. .... Madison Clinic  
Petway, Allen P. .... 426 E. Main  
Prenatt, Francis ..... Madison State Hospital

Shuck, Wm. A. .... Odd Fellows Bldg.  
Totten, Evan C. (S) ..... 415 W. 2nd St.

Turner, Anna L. .... 104 E. Third  
Turner, Oscar A. .... 104 E. Third  
Whitsitt, Schuyler A. (S) ..... 718 W. Main  
Zink, Robert O. .... Madison Clinic

Bear, Lowery, H. (S) ..... Vevay  
Ellerbrook, George E. .... Vevay  
Graves, Noel S. .... Vevay  
Person, Theodore ..... Vevay  
Cook, Elbert C. (S) ..... R.R. 1, Bradenton, Fla.  
Sharman, Edward J. .... VA Hospital, Marion, Ill.

## JENNINGS COUNTY

Calli, Louis ..... North Vernon  
Green, John H. .... North Vernon  
Matthews, Dennis W. .... North Vernon  
Stemm, Wm. H. (S) .... North Vernon  
Thayer, Benet W. .... North Vernon

## JOHNSON COUNTY

Dettman, John ..... Edinburg  
Manuel, Donald ..... Edinburg  
Michaels, Joseph F. (S) .... Edinburg  
Deppe, Charles F. .... Franklin  
Eaton, Lyman D. .... Franklin  
Ferrara, Joseph F. .... Franklin  
Jones, Charles A. .... Franklin  
Murphy, Harry E. .... Franklin  
Portteus, Walter L. .... Franklin  
Province, Oran A. .... Franklin  
Province, William D. .... Franklin  
Records, Arthur W. .... Franklin  
Wilson, Russell C. .... Franklin  
Barnes, Helen Beall. .... Greenwood  
Brown, George E. .... Greenwood  
Sheek, Kenneth L. .... Greenwood  
Tiley, George A. .... Greenwood  
Woodcock, Charles E. .... Greenwood  
Machledt, John H. .... Whiteland

## KNOX COUNTY

Byrne, Robert J. .... Bicknell  
Donham, William L. .... Bicknell  
Fox, Richard H. (S) .... Bicknell  
Meade, Walter W. .... Bicknell  
Wilson, Guy H. .... Bicknell  
Scudder, John A. .... Edwardsport  
Raper, Geo. T. .... Freelandville  
Hodges, William A. .... Oaktown  
Springstun, George H. .... Oaktown  
Pahmeier, John W. .... Sandborn  
Lutes, David L. .... Wheatland

### Vincennes

Anderson, Richard M. ....  
301 LaPlante Bldg.  
Arbogast, Paul B. .... 915 Main  
Bailey, W. A. (S) .... 516 Busseron  
Beckes, N. E. (S) .... 414 Broadway  
Boyd, Claudius L. (S) ..... 114 N. Fourth  
Chattin, Herbert O. .... 729 Main  
Coffel, Melvin H. .... 424 LaPlante Bldg.

Cullison, Charles W. .... R.R. 4  
Curtner, Myron L. .... 222 N. Sixth  
Davis, Howard B. .... 621 Seminary St.  
Edwards, Edward T., Jr. .... 1045 Washington Ave.

Ewing, Nathaniel D. .... 14 N. Third  
Fox, Maurice S. .... 616 Shelby St.  
Gilmore, Louis L. (S) ..... 430 N. 2nd St.

Green, Carl L. .... 1004 Main  
Hoffman, Doris. .... 324 Vigo  
Humphreys, Joe E. .... 217 N. Third  
Johnson, Morris H. C. .... R.R. 1  
Keezer, William S. .... Vincennes  
McCormick, Hubert D. .... 325 LaPlante Bldg.

McDowell, Mordecai M. .... 211 American Bank Bldg.  
McMahan, Virgil C. .... 410 LaPlante Bldg.

Meyer, Raymond C. .... Hillcrest Hosp.  
Moore, Robert G. .... 21 N. Third  
Nance, William K. .... 324 Vigo  
Reilly, James F. .... 401 Buntin St.  
Richards, D. H. (S) ..... 215 American Nat. Bk. Bldg.

Schulze, William .... 223 American Bank Bldg.  
Shaffer, Kenneth L. .... 404 LaPlante Bldg.

Smith, Ralph O. .... 12 S. Fourth

Smith, Saml. J. .... 301 LaPlante Bldg.  
Spencer, Frederic ..... 421 LaPlante Bldg.  
Sullenger, A. A. .... 803 Seminary St.  
Welch, Norbert M. .... 410 LaPlante Bldg.

## KOSCIUSKO COUNTY

McIlroy, Richard J. .... Claypool  
Thomas, Charles E. (S) .... Leesburg  
Urschel, Dan ..... Mentone  
Waltz, Frank C. .... Mentone  
Stalter, Gaylord W. .... N. Webster  
Schuldt, T. S. .... Pierceton  
King, James R. .... Silver Lake  
Clark, Fred ..... Syracuse  
Craig, Robert A. .... Syracuse  
Fosbrink, E. L. .... Syracuse  
Haymond, George M. .... Warsaw  
Hillery, John L. .... Warsaw  
Richer, Orville H. .... Warsaw  
Roesch, Ryland. .... Warsaw  
Schlemmer, George H. .... Warsaw  
Thomas, Everett W. .... Warsaw  
Mason, Harold. .... Winona Lake

## LAGRANGE COUNTY

Wade, Alfred A. .... Howe  
Yunker, Philip E. .... Howe  
Benedict, Charles D. .... LaGrange  
Flannigan, Harley F. .... LaGrange  
Studebaker, Lloyd R. .... LaGrange  
Weir, Dale ..... LaGrange  
Robertson, Wm. .... Shipshewana  
Hildebrand, William O. (S) .... Topeka  
Lehman, Kenneth M. .... Topeka

## LAKE COUNTY

Bolin, John T. .... Cedar Lake  
King, Robert W. .... Cedar Lake  
Misch, William ..... Cedar Lake

### Crown Point

Becker, Philip H. .... Lake County T. B. Sanitarium  
Birdzell, John P. .... 124 N. Main  
Carroll, Mary E. .... 124 N. Main  
Gray, Daniel E. .... 235 S. Main  
Hasler, Norman B. .... Lake County T.B. Sanitarium

Horst, William N. .... 138 S. Main  
Iddings, John W. .... 124 N. Main  
Klaus, J. M. .... 224 S. Court  
Merchant, Raymond. .... 269 Maxwell  
Monroe, F. Bruce. .... Crown Point  
Seyler, Anna G. .... Lake County T. B. Sanitarium

Steele, Everett B. .... 124 N. Main  
Troutwine, William ..... 224 S. Court  
Weis, William D. (S) .... Court House

Adler, Edmund R. .... Dyer

### East Chicago

Arnold, M. F. .... 4614 Indianapolis Blvd.  
Barron, Elmer A. .... 3406 Guthrie St.  
Beam, Vernon B. .... Du Pont Co.  
Beilke, Clifford A. .... 815 W. Chicago  
Benchick, Frank A. .... 4712 Magoun Ave.

Benedek, Tibor. .... 3406 Guthrie St.  
Bonaventura, Angelo P. .... 3701 Main St.



## LAKE COUNTY

(East Chicago—Continued)

Boyd, Chas. S. . . 4739 Melville Ave.  
Boys, Fay F. . . 722 W. Chicago Ave.  
Brauer, Abraham A. . 3528 Main St.  
Braun, Benjamin D.

St. Catherine's Hospital  
Broomes, Edw. L. . 2301 Broadway  
Callahan, Richard H. . 3704 Main St.  
Campagna, Ettro A. . 3406 Guthrie  
Carleton, Edward H.

Inland Steel Co.  
Cole, Arthur V. . . 3406 Guthrie St.  
Cotter, Edward R.

723 W. Chicago Ave.  
Dainko, Alfred J.

823 W. Chicago Ave.  
Ernst, H. C. . . 720 W. Chicago Ave.  
Fleischer, Jacob C. . . 3406 Guthrie  
Gardiner, H. Glenn . . 3210 Watling  
Govorchin, Alexander

724 W. Chicago Ave.  
Grosso, William G.

722 W. Chicago Ave.  
Gustaitis, John W.

815 W. Chicago Ave.  
Hamilton, Robert C.

2602 E. 140th Place  
Hayes, Jesse D. . . . 4742 Melville  
Irish, Wilbur J.

806 W. Chicago Ave.  
Johns, David R.

724 W. Chicago Ave.  
Kaplan, Benjamin B. . 3738 Main St.  
Komoroske, John E.

723 E. Chicago Ave.  
Levin, Eli . . . . . 3700 Main St.  
McGuire, Desmond F.

3429 Michigan Ave.  
Marks, Ora L. . 815 W. Chicago Ave.  
Nicosia, John B. . . . 3701 Main St.  
Payne, Arthur C. . . 2020 Broadway  
Petronella, Samuel J.

4614 Indianapolis Blvd.  
Ramker, Daniel T.

3406 Guthrie Ave.  
Shapiro, Joseph . . . . 3701 Main St.  
Shulruff, H. I. . . . 3701 Main St.  
Teegarden, Joseph A., Jr.

3336 Michigan Ave.  
Teegarden, Joseph A.

3336 Michigan Ave.  
Trepagnier, Francis B.

3616 Main St.  
Zallen, Stanley G.

720 W. Chicago Ave.  
Zivich, John M. . . . 3701 Main St.

## Gary

Almquist, Carl O. . . 504 Broadway  
Armalavage, Leon J. . 504 Broadway  
Auten, Donald S. . . 504 Broadway  
Baitinger, Herbert M.

504 Broadway  
Behn, Walter M. . . . 738 Broadway  
Bender, Carl H. . . . 738 Broadway  
Bills, Robert N. . . . 504 Broadway  
Boardman, Carl . . . 504 Broadway  
Borak, Walter J. . 6151 W. 25th Ave.

Brady, Samuel G. . . 765 Broadway  
Brandman, Harry . . 504 Broadway  
Brink, Calvin C. . . 504 Broadway  
Brown, David B. . . 504 Broadway  
Brown, Leo R. . . . 3855 Broadway

Bullard, Mattie J. . . 524 Garfield St.  
Burcham, James B. . 738 Broadway  
Carbone, Joseph A. . 504 Broadway

Carmody, Raymond F.

504 Broadway  
Chevigny, Julius J. . 504 Broadway  
Cooper, Leo K. . . . 670 Hayes St.  
Crossland, Steward H.

560 Hayes St.  
Danieleski, L. J. . . 738 Broadway

Darling, Dorothy . 1600 W. 6th Ave.  
Davis, Neal, Box 928, Ogden Dunes

Dian, August J. . . 729 Broadway  
Dian, Julia . . . . 729 Broadway

Dierolf, Edward J. . 504 Broadway  
Donchess, Joseph C. . 215 Broadway

Doty, James R. . . . 504 Broadway  
Duncan, John S. . . 2165 W. 11th St.

Elliott, Ralph A. . . 504 Broadway  
English, Hubert M. . 673 Broadway

Franklin, Philip . . 936 W. 5th Ave.  
Gannon, G. W. . . . 602 Broadway

Goldberg, Harold B. . 515 Broadway  
Goldstone, Adolph . . 757 Broadway

Goldstone, Joseph . . 757 Broadway  
Goldstone, S. R. . . 757 Broadway

Gorton, Mary L. . . 400 Broadway  
Grant, Benjamin . . 1706 Broadway

Gregoline, A. F. . . 729 Broadway  
Gutierrez, F. A. . . 504 Broadway

Hasl, Robert F.

3562 Washington St.  
Hedrick, James T. . 1901 Broadway

Hodurski, Zigfield . . 4319 Broadway  
Holmes, George W. . . 504 Broadway

Jannasch, Maurice C. . 738 Broadway  
Johnson, Lonnie B.

123 W. 21st St.  
Kahan, Harry L. . . 738 Broadway

Kendrick, Frank J. . 504 Broadway  
Kobrin, Meyer W. . . 729 Broadway

Kolettis, George J. . 860 Broadway  
Kopcha, Joseph E. . . 504 Broadway

Korn, Jerome M. . . 742 Broadway  
Kron, R. Vincent

3538 Central, East Gary  
Lebioda, Henry S. . . 8 W. Ridge Rd.

Lewis, George N. . . 504 Broadway  
Lorenty, Thaddeus B.

738 Broadway  
Lovell, Martin H. . . 1606 Broadway

Lutz, Georgianna . . 504 Broadway  
McMichael, F. J. . . 504 Broadway

Majsterek, Stanley L.

1902 W. 11th Ave.  
Marcus, Morris C. . . 738 Broadway

Marshall, Millard R. . 504 Broadway  
Mather, J. W. . . . 3543 Central,

East Gary  
May, Richard M. . . 583 Broadway

Minczewski, Richard C.

504 Broadway  
Molengraft, Cornelius J.

527 Broadway  
Moore, E. Gregory . 1901 Broadway

Moore, Edwin G. . . 1606 Broadway  
Morris, Hyman . . . 17 W. 8th Ave.

Moswin, Jack A. . . 504 Broadway  
Nelson, Walfred R. . 559 S. Lake St.

Neuwelt, Frank . . . 504 Broadway  
Ornelas, Jos. P. . . 673 Broadway

Palmer, Russell H.

2006 W. 4th Place  
Parker, Harry C. . . 673 Broadway

Parratt, Louis W. . . 708 Broadway  
Reynolds, James S. . 504 Broadway

Robinson, Walter K. . 504 Broadway  
Rosenbloom, Philip J.

504 Broadway  
Roth, Leo . . . . . 738 Broadway

Rubin, Simon S. . . 504 Broadway

Ryan, Hubert J. . . . 504 Broadway  
Sagel, Jacob . . . . 504 Broadway

Sala, Joseph J. . . . 504 Broadway  
Sala, Walter R. . . . 504 Broadway

Schaible, Ernest L. . 738 Broadway  
Senese, Thos. J. . . . 504 Broadway

Shellhouse, Michael

3811 Washington St.  
Skeen, Earl D. . . . 504 Broadway

Slama, George D. . . 3624 Buchanan  
Slama, John T. . . . 4481 Broadway

Spellman, Frank W. . 564 S. Lake  
Spivack, Mary . . . 3855 Broadway

Sponder, Joseph . . 1512 Broadway  
Stimson, H. R. . . . 504 Broadway

Stoycoff, Christo M. . 844 Broadway  
Templin, David B. . . 504 Broadway

Thomas, Daniel D. . . 738 Broadway  
Thomas, Gerald J. . . 504 Broadway

Trinosky, Donald L. . 504 Broadway  
Turgi, Robert W. . . 673 Broadway

Verplank, Grover L. . 527 Broadway  
Vye, James P. . . . 607 Broadway

Walters, Eleanore . . 522 Broadway  
Washington, G. Kenneth

1606 Broadway  
Weiskopf, Henry S. . 504 Broadway

Wharton, Russell O.

703 Johnson St.  
White, W. J. (S) . . . 790 Broadway

Wicks, Orlando C. (S)

560 Van Buren  
Williams, Alexander S.

504 W. 25th St.  
Wimmer, Robert N. . . 9 W. 6th St.

Yarrington, Charles W. (S)

607 Broadway  
Yocum, Paul S. . . . 738 Broadway

Yocum, Wm. S. . . . 583 Broadway  
Young, George M. . . 3776 Broadway

Young, Robert L. . . . 11 7th Ave.

Hazinski, R. T. . . . . Griffith

Lundeberg, Ralph A. . . . Griffith

Malmstone, F. A. (S) . . . Griffith

Purcell, Richard J. . . . Griffith

Siekierski, Joseph M. . . . Griffith

## Hammond

Allegretti, Michael L.

5404 Hohman Ave.  
Arbeiter, Herbert I.

5231 Hohman Ave.  
Arrowsmith, James L.

5231 Hohman Ave.  
Beconovich, Robt.

839-169th St.  
Bethea, Dennis . . . 1021 Fields St.

Brown, Stanley L.

6550 Hohman Ave.  
Carlo, Joseph F.

5305 Hohman Ave.  
Chidlaw, B. W. . . 5141 Hohman Ave.

Clancy, James F.

5231 Hohman Ave.  
Cook, George M.

5231 Hohman Ave.  
Davis, Alice L. . . 5116 Hohman Ave.

Detrick, Herbert W.

6427 Forest Ave.  
Eggers, Ernest L.

5141 Hohman Ave.  
Eggers, Henry W.

5231 Hohman Ave.  
Egnatz, Nicholas . . 522½ State St.

Elledge, Ray . . . 5231 Hohman Ave.  
Fischer, Burnell

7403 Van Buren Ave.



## LAKE COUNTY

(Hammond—Continued)

Friedman, Isadore E.  
5248 Hohman Ave.  
Gevirtz, Milton B.  
5246 Hohman Ave.  
Groman, Herman C. 137 Rimbach  
Hack, Edmund C.  
5217 Hohman Ave.  
Hansen, Arthur H.  
5252 Hohman Ave.  
Hickman, A. L. 5248 Hohman Ave.  
Hofmann, Andrew  
5135 Hohman Ave.  
Hopkins, J. R. 5217 Hohman Ave.  
Howard, William H.  
5231 Hohman Ave.  
Husted, Robert G.  
5248 Hohman Ave.  
Jones, Eli S. 5231 Hohman Ave.  
Justen, Jerome W.  
5231 Hohman Ave.  
Kolanko, Leon A.  
5435½ Hohman Ave.  
Koransky, David S.  
5231 Hohman Ave.  
Kretsch, R. W. 5231 Hohman  
Kuhn, Hedwig S. 112 Rimbach St.  
Kuhn, Hugh A. 112 Rimbach St.  
Larrabee, James F.  
5245 Hohman Ave.  
Lautz, Herbert A. 112 Rimbach St.  
Lazo, Vicente R.  
5446 Calumet Ave.  
Lipsey, Alfred J.  
5252 Hohman Ave.  
McLean, James S.  
5252 Hohman Ave.  
McVey, Clarence A.  
5231 Hohman Ave.  
Marcus, Emanuel  
5252 Hohman Ave.  
Marks, Salvo 409 Yale Bldg.  
Mason, Richard L. 132 Rimbach St.  
Matthews, Charles B. (S)  
5252 Hohman Ave.  
Modjeski, Joseph R.  
5451½ Hohman Ave.  
Modjeski, Raymond J.  
5231 Hohman Ave.  
Morrison, Lindsey (S)  
109 Rimbach St.  
Murphy, Joseph F., Jr.  
139 Rimbach St.  
Musacchio, Frederick A.  
330 City Hall  
Nakadate, K. James  
917 173rd Place  
Neal, Leonard W.  
5252 Hohman Ave.  
Nelson, Richard B.  
5618 Calumet Ave.  
Nodinger, Louis 540 165th St.  
Panares, Solomon V.  
5434 Hohman Ave.  
Paul, William Thomas F.  
5434 Hohman Ave.  
Peck, Edward A. 422 Conkey St.  
Peiffer, Geraldine M.  
5231 Hohman Ave.  
Pilot, Jean 5231 Hohman Ave.  
Premuda, F. F. 6727 Kennedy Ave.  
Rawlins, Carolyn M.  
422 Conkey St.  
Remich, Antone C. 137 Rimbach St.  
Rendel, Donald T.  
5231 Hohman Ave.

Rhind, A. W. 5145 Hohman Ave.  
Rosenthal, Carl 5252 Hohman Ave.  
Rosevear, Henry S.  
5231 Hohman Ave.  
Row, Perrie Q. 5231 Hohman Ave.  
Rudolph, Franklin G.  
5231 Hohman Ave.  
Schlesinger, Jacob  
6010 Columbia Ave.  
Schulfer, Richard J.  
6719 Calumet Ave.  
Shanklin, E. M. (S)  
5141 Hohman Ave.  
Skrentny, Stanley  
5231 Hohman Ave.  
Sosson, Edward 112 Rimbach  
Sroka, Alexander G.  
6010 Columbia Ave.  
Stasick, Murray 60 Douglas St.  
Stern, Samuel L.  
5231 Hohman Ave.  
Tilka, Edward 6719 Calumet St.  
Walker, Adolph P. 1135 River Drive  
Wood, Frederic H.  
49 Muenich Court  
Zeman, Theodore C.  
112 W. Rimbach St.

Acos, James C.  
2805 Highway Ave., Highland  
Markey, Richard J. P.  
2805 Highway Ave., Highland  
Sroka, Stanley J.  
8606 Kennedy Ave., Highland  
Vore, Hugh A. 8680 Prairie Ave.  
Bjorklund, C. Ray Hobart  
Dupes, Lowell E. Hobart  
Friedrich, Louis M. (S) Hobart  
Markle, Joseph G. Hobart  
Pike, Warren H. Hobart  
Reed, John Hobart  
Storer, W. R. Lowell  
Combs, Loyal Lowell  
Mirro, John A. Lowell  
Campbell, Guy C. Munster  
Teplinsky, Louis L. Munster

## Whiting

Bechtol, Lavon D.  
1902 Indianapolis Blvd.  
Ferry, John  
1902 Indianapolis Blvd.  
Frankowski, Clementine E.  
1907 New York Ave.  
Greisen, Jack G.  
1902 Indianapolis Blvd.  
Jones, Clifford M.  
1902 Indianapolis Blvd.  
Kudele, Louis T. 1321 119th St.  
LaFollette, Forrest R.  
1900 Indianapolis Blvd.  
McCarthy, Jeremiah A.  
1341 E. 119th St.  
Rudser, Donald H.  
1902 Indianapolis Blvd.  
Silvian, Harry A. 1400 119th St.  
Smith, Theodore J.  
1902 Indianapolis Blvd.  
Stecy, Peter  
1902 Indianapolis Blvd.  
Thegze, G. A. 1344 119th St.  
Troy, Jack M.  
1900 Indianapolis Blvd.  
Weinberg, B. A. 1348 119th St.  
Bergan, Joseph A.  
VA Hosp., McKinney, Texas

Dassel, Paul M.  
44 S. 20th St., Maywood, Ill.  
Galante, Vincent J.  
2414 Kimball, Chicago, Ill.  
Jahns, Albin A. 116 S. Michigan  
Ave., Chicago 3, Ill.  
Kobrak, H. G. 950 E. 59th St.,  
Chicago 31, Ill.  
Kopanko, Bernard F. St. Mary's  
Hosp., Huntington, W. Va.  
O'Connor, James J. 3841 Colles  
Ave., Los Angeles 33, Calif.  
Richter, Samuel  
Charity Hosp., New Orleans, La.  
Rubin, Milton R. 605 T. W.  
Patterson Bldg., Fresno, Calif.  
Schlesinger, Daniel J. Presbyterian  
Hosp., Pittsburgh, Pa.  
Stevens, Edwin W. 586 State Line  
St., Calumet City, Ill.  
Tyrrell, Thomas C.  
704 Wentworth Ave.,  
Calumet City, Ill.

## LAPORTE COUNTY

Oak, David, Jr. Hanna  
Oak, David D. LaCrosse

## LaPorte

Carter, Fred S. 920 Indiana Ave.  
Cartwright, Jack D.  
806 Madison St.  
Cleveland, John B.  
801 Washington St.  
Elshout, Clem H. 1004 Indiana Ave.  
Fargher, Robert A.  
811 Jefferson Ave.  
Farnsworth, Samuel A.  
1012 Michigan Ave.  
Fein, Harry S. 706A Jefferson Ave.  
Fischer, Carlton N.  
1001 Maple Ave.  
Jones, John C. 801 Madison  
Jones, Robert B.  
808 Michigan Avenue  
Kelly, Jon N. (S)  
704 Jefferson Ave.  
Kelsey, Robert M. 702 Maple Ave.  
Kepler, Robert W. 708 Harrison St.  
Kistler, James J. 911 Maple Ave.  
Larson, G. O. 1110 Indiana Ave.  
Linn, Elbert E. 809 Jefferson St.  
Martin, William B.  
812 Michigan Ave.  
Morgan, Samuel P.  
810 Michigan Ave.  
Muhleman, C. E. 901 Indiana Ave.  
Przednowek, Adolph C.  
909 Madison St.  
Richter, John C. 808 Michigan Ave.  
Ross, Wilbur W. P. O. Box 102  
Scott, John S. 806 Maple Ave.  
Simon, Arthur R. 806 Maple Ave.  
Von Asch, George 912 Monroe St.  
Wilcox, Robert F. 808 Maple Ave.

## Michigan City

Armstrong, Thomas D.  
120 W. Ninth St.  
Baker, Warren 427 Warren Bldg.  
Bankoff, Milton L. 123 E. 5th St.  
Bernoske, Daniel G. 731 Pine St.  
Brooks, Harry L. 123 E. 5th St.  
Burris, Floyd L. 731 Spring St.  
Carlson, Norman R. 229 E. 5th St.



**LAPORTE COUNTY**

(Michigan City—Continued)

Donovan, Stephen J.  
916 Washington St.  
Fargher, Francis M.  
723 Franklin St.  
Feerer, Donald. 117 W. Seventh St.  
Flaherty, Walter T.  
1016 Washington St.  
Frost, Robert J. . . . . 817 Pine St.  
Gardner, Melvin D.  
801 Washington St.  
Gardner, Russell A.  
801 Washington St.  
Gilmore, Robert W.  
216 W. 9th St.  
Gilmore, Russell A.  
301 Warren Bldg.  
Grotts, Bruce F.  
801 Washington St.  
Harris, Albert J. . . . Warren Bldg.  
Henderson, N. C.  
622½ Franklin St.  
Hillenbrand, Charles  
128 W. Tenth St.  
Jones, King Solomon  
328½ Franklin St.  
Kemp, John T. . . . . 122 E. 7th St.  
Kerrigan, Robert L.  
916 Washington St.  
Kling, Victor F. . . 507 Warren Bldg.  
Kohrman, Benjamin M.  
123 E. Fifth St.  
Kress, James W. . . . 125 E. 5th St.  
Krieger, George M.  
701 Washington St.  
Kubik, Francis J. . . . 201 E. 8th St.  
Lava, Irving M. . . . . 125 E. 5th St.  
Meyer, Milo G. 801 Washington St.  
Molenda, Robert V. . . 902 Pine St.  
Piazza, Leonard F.  
404 Warren Bldg.  
Pilecki, Peter J. . . . 125 E. 5th St.  
Plank, C. Robert. . . 732 E. Pine St.  
Reed, Ann M. . . . . 123 E. Fifth St.  
Reed, Nelle . . . . . 501 Pine St.  
Robrock, Lawrence M.  
315 Warren Bldg.  
Spinning, A. L. (S)  
Kenwood Place  
Straus, David C. . . . 123 E. Fifth St.  
Walters, William H. . . Warren Bldg.  
Warren, Frank R. (S)  
723 Franklin St.  
Weeks, Patrick H. . . . . Box 41

Weinstock, Adolph. Rolling Prairie  
Moosey, Louis . . . . . Union Mills  
Eades, R. Charles . . . . Westville  
Hetman, Mitchell J. . . . Westville  
Townsend, Ralph . . . . Westville  
Benz, Owen . . . . . Wanatah

**LAWRENCE COUNTY**

Bedford

Allen, L. Howard  
305 Citizens Nat. Bank Bldg.  
Austin, Richard P.  
209 Citizens Nat. Bank Bldg.  
Benham, L. E.  
206 Citizens Bank Bldg.  
Bridwell, Edgar . . . . . 1317 L St.  
Dusard, Joseph C.  
304 Citizens Nat. Bank Bldg.

Edmonds, Kendrick . . 1303 15th St.  
Emery, Charles B. . . . 1027 15th St.  
Fountaine, Thomas J.  
200 Citizens Nat. Bank Bldg.  
Hammel, Howard T.  
Citizens Nat. Bank Bldg.  
Kerr, Donald M. . . . . 1317 L St.  
Martin, Frank D. . . . . 1501 I St.  
Meyer, Orlando L. . . . 1317 L St.  
Newland, Arthur E. . . 1112 15th St.  
Noe, William R. . . . . Bedford  
Pearson, John R. (S)  
Citizens Nat. Bank Bldg.  
Robertson, Moorman O.  
400 Citizens Nat. Bank Bldg.  
Scherschel, John P. . . . 1711 H St.  
Smallwood, Robert B.  
204 Citizens Nat. Bank Bldg.  
Wohlfeld, Julius B. . . 1124 16th St.  
Woolery, Richard  
207 Citizens Nat. Bank Bldg.  
Wynne, Roland E.  
301 Citizens Nat. Bank Bldg.

Hamilton, James R. . . . Mitchell  
Oswalt, James Telfer . . Mitchell  
Strickland, William B. . . Mitchell  
Dollens, Claude . . . . . Oolitic

**MADISON COUNTY**

Carpenter, John L. . . . Alexandria  
Gaunt, Everett W. . . . Alexandria  
Keller, Frank G. (S) . . Alexandria  
Overpeck, George H. . . Alexandria  
Shafer, Richard H. . . . Alexandria

Anderson

Aagesen, Walter J.  
615 Citizens Bank Bldg.  
Armington, Charles L.  
657 Anderson Bank Bldg.  
Armington, John C. (S)  
657 Anderson Bk. Bldg.  
Armington, Robert L.  
318 Citizens Bank Bldg.  
Austin, Charles E.  
2108 Nichol  
Austin, Maynard A. (S)  
238 W. 12th St.  
Ayres, Kenneth D.  
2210 Meridian St.  
Baughn, William L.  
Guide Lamp Div.  
Benoit, Merrill P. . . . Delco Remy  
Bixler, Donald P. . . 1410 Brown St.  
Blassaras, Chris . . . 2005 Broadway  
Brauchla, Carl H. . . 117 W. 17th St.  
Brock, Earl E. . . . . 931 Meridian St.  
Brown, James M.  
609 Anderson Bldg.  
Buckles, David L. St. John's Hosp.  
Conrad, Ernest M. (S)  
2124 Meridian  
Dixon, Rex W. . . . . 934 W. 8th St.  
Doenges, James L.  
631 Citizens Bank Bldg.  
Donaldson, Frank C.  
712 Anderson Bank Bldg.  
Drake, John C.  
604 Anderson Bank Bldg.  
Ellis, Seth W.  
717 American Bank Bldg.  
Elsten, Aubrey W.  
704 Anderson Bank Bldg.  
Erehart, Archie D.  
714 Anderson Bank Bldg.

Fischer, Warren E.  
St. John's Hospital  
Gante, Henry W.  
1110 N. Meridian St.  
Guthrie, Francis C.  
412 Anderson Bank Bldg.  
Hart, William D.  
515 Citizens Bank Bldg.  
Hensler, Benton M. . 12 W. 29th St.  
Irwin, Seth. . . . . 2209 Cedar St.  
Jarrett, Paul E.  
315 Citizens Bank Bldg.  
Jones, Albert T.  
712 Anderson Bank Bldg.  
Jones, Horace E.  
1110 Meridian St.  
Kelly, Wendell C. . . . 704 E. 8th St.  
King, Joseph W.  
1110 N. Meridian St.  
Kopp, Otis A. . . . . 1110 N. Meridian St.  
Lamey, James L.  
447 Citizens Bank Bldg.  
Lamey, Paul T.  
423 Citizens Bank Bldg.  
Larmore, Joseph L.  
712 Anderson Bank Bldg.  
Larmore, Sarah M. . . . . R. R. 8  
Litzenberger, Sam W.  
622 Citizens Bank Bldg.  
Long, Paul L.  
710 Anderson Bank Bldg.  
McDonald, Vergil G.  
1110 Meridian St.  
Meister, Doris  
403 Citizens Bank Bldg.  
Metcalf, George B.  
931 Meridian St.  
Miley, Weir M. . . . 717 Madison St.  
Morris, Robert A.  
320 Citizen Bank Bldg.  
Neale, Alfred  
234 Citizens Bank Bldg.  
Nelson, Paul L. . . . 330 West 7th St.  
Nesbit, Leonard L.  
415 Citizens Bank Bldg.  
Patterson, William K.  
St. John's Hospital  
Polhemus, Warren C.  
1803 Pearl St.  
Quickel, Daniel S. (S)  
5 Griffith Bldg.  
Reed, Roger R.  
412 Anderson Bank Bldg.  
Rosenbaum, Lloyd E.  
647 Citizens Bank Bldg.  
Ross, Guy E.  
661 Citizens Bank Bldg.  
Rozelle, Clarence V.  
615 Citizens Bank Bldg.  
Sharp, William L.  
449 Citizens Bank Bldg.  
Stamper, Joseph H. . . R. R. 7, Bx. 47  
Swan, Richard C. . . . Delco Remy  
Tracy, Julius R. . . . 738 W. 8th St.  
Webb, Harry . . . . . 105 W. 11th St.  
Wilder, Gordon B.  
612 Anderson Bank Bldg.  
Wilkinson, Roger L. . 4 E. 38th St.  
Williams, Francis . . . 1132 Central  
Williams, Robert H.  
1132 Central Ave.  
Willson, Canby L.  
615 Anderson Bank Bldg.  
Wright, Cecil S.  
523 Citizens Bank Bldg.  
York, Arthur F.  
602 Citizens Bank Bldg.  
Zierer, R. O. . . . . 931 Meridian



## MADISON COUNTY

## Elwood

Cullipher, Jeremiah E. (S)  
903 Main St.  
Drake, M. C. . . . . 1201 Main St.  
Fitzpatrick, Harry W.  
1309 S. Anderson St.  
Hanson, Martin F.  
1102 S. Anderson St.  
Hoppenrath, Wesley M.  
1300 Main St.  
Hoppenrath, William H. (S)  
1300 Main St.  
Laudeman, Walter A.  
1515 North A St.  
Newcomer, Frank V.  
608 S. Anderson St.  
Ploughe, Monroe L. (S)  
517 S. Anderson St.  
Ploughe, Ralph R. 517 S. Anderson  
Scea, Wallace. . . . . 1300 Main St.

Bishop, Harry A. . . . . Frankton  
Maxon, Roy V. . . . . Lapel  
Rinne, John I. . . . . Lapel  
Williams, Robert D. . . . Markleville  
McLaughlin, Calvin P. . . . Pendleton  
Sisson, Helen M. . . . . Pendleton  
VanNess, William C. . . . Summitville  
McVaugh, Charles C.  
4503 N. Winchester, Chicago, Ill.

## MARION COUNTY

Berger, Morley  
902 Main St., Beech Grove  
Kim, Young D.  
136 N. 17th St., Beech Grove  
Ramage, Walter F.  
244 S. First St., Beech Grove  
Rhea, James C.  
801 Main St., Beech Grove  
Briggs, Robert W. . . . R. 1, Box 107  
Bridgeport  
Hade, F. L. . . . . Bridgeport  
Zerfas, Leon G. . . . R. 1. Camby  
Garrison, James L. . . . Cumberland  
Miller, Joseph A. . . . Cumberland

## Indianapolis

## A

Abreu, Benedict E.  
1200 Madison (6)  
Adkins, Harold C. . . 409 E. 30th (5)  
Adkins, Onan C.  
3635 Watson Rd. (5)  
Albertson, Frank P.  
3544 W. 16th St. (22)  
Aldrich, Harry D.  
501 Hume Mansur Bldg. (4)  
Aldrich, Howard  
4316 E. Washington (1)  
Alexander, Ezra D.  
617 Indiana, No. 304 (2)  
Allen, Robert K.  
3202 N. Meridian St. (8)  
Alvis, Edmond O.  
320 Hume Mansur Bldg. (4)  
Anderson, Wendell C.  
1330 W. Michigan (7)  
Appel, Richard H.  
603 Hume Mansur Bldg. (4)  
Arbogast, J. L.  
I.U. Med. Center (7)

Arbuckle, Wm. E. . . . 1156 Lee (21)  
Arnold, Aaron L.  
607 E. Maple Rd. (5)  
Arnold, Robert D. 3419 E. 10th (1)  
Aronson, Sidney S.  
618 Hume Mansur Bldg. (4)

## B

Bachmann, Arnold J.  
3440 N. Meridian (8)  
Bahr, Max A. (S)  
Central State Hospital (22)  
Bailey, Orville T.  
1315 W. 10th St. (2)  
Bakemeier, Otto H.  
5503 E. Washington (19)  
Balch, James F.  
709 Hume Mansur Bldg. (4)  
Ball, John R. . . 1418 W. 10th St. (2)  
Ball, Joseph E. . . 4312 E. 10th (1)  
Banister, Revel F. 2958 Central (5)  
Banks, Horace M.  
Methodist Hosp. (7)  
Barry, M. Joseph, Sr.  
508-509 Doctors' Bldg. (4)  
Bartley, Max D.  
803 Hume Mansur Bldg. (4)  
Batman, Gordon W.  
723 Hume Mansur Bldg. (4)  
Battersby, J. Stanley  
I. U. Medical Center (7)  
Batties, Paul A.  
308 Walker Bldg. (2)  
Bauer, Thomas B.  
408 Hume Mansur Bldg. (4)  
Baum, Harry  
VA Regional Office (9)  
Baumeister, Herbert E.  
3375 Forest Manor (18)  
Beach, Robert R. . . 2630 E. 10th (1)  
Bean, Joseph S. . . General Hosp. (7)  
Beasley, Thomas J.  
112 Berkley Rd. 8)  
Beaver, Howard W.  
11 E. Raymond (25)  
Beck, Evart M.  
633 E. Maple Rd. (5)  
Beckman, Henry F. (S)  
5245 Washington Blvd. (20)  
Beeler, John W.  
712 Hume Mansur Bldg. (4)  
Beeler, Raymond C.  
712 Hume Mansur Bldg. (4)  
Behnke, Roy H.  
I.U. Medical Center (7)  
Bergwall, Warren L.  
General Hosp. (7)  
Berman, Edward J.  
807 Hume Mansur Bldg. (7)  
Berman, Jacob K.  
807 Hume Mansur Bldg. (4)  
Beverland, Malon E.  
3036 E. Washington (1)  
Bibler, Lester D.  
811 Underwriters Bldg. (4)  
Bird, Charles R. (S)  
301 Hume Mansur Bldg. (4)  
Bivin, James H.  
502 Hume Mansur Bldg. (4)  
Blatt, A. Ebner  
3209 N. Meridian (8)  
Bloemker, Edward F.  
2729 Shelby (3)  
Boaz, John J. (S)  
302 K. of P. Bldg. (4)  
Bock, Don G. . . 5249 Crittenden (20)  
Boggs, Eugene F.  
2901 N. Meridian St. (8)

Bohner, Caryle B.  
822 Hume Mansur Bldg. (4)  
Boling, Grover C., Jr.  
1441 N. Delaware (2)  
Bond, George S.  
1221 N. Delaware St. (2)  
Bond, Virginia  
2012 Sharon Ave. (22)  
Booher, Norman R.  
447 E. Maple Rd. (5)  
Booher, Olga Bonke  
447 E. Maple Rd. (5)  
Booth, Boynton H.  
910 Hume Mansur Bldg. (4)  
Bowers, Don D.  
711 Underwriters Bldg. (4)  
Bowman, George W.  
1140 E. Market (2)  
Bowman, Harold E.  
I.U. Medical Center (7)  
Boyer, Edward B.  
725 Hume Mansur Bldg. (4)  
Boyer, Floyd A. . . 442 N. Drexel (1)  
Brady, Thomas A.  
818 Hume Mansur Bldg. (4)  
Brayton, John R.  
704 Underwriters Bldg. (4)  
Brayton, Lee. . . 3342 N. Illinois (8)  
Bridges, William L.  
I.U. Medical Center (7)  
Brincko, John Methodist Hosp. (7)  
Brockmeier, Frederick  
Methodist Hosp. (7)  
Brodie, Donald W.  
817 C. of C. Bldg. (4)  
Brown, Archie E.  
1220 S. Belmont (21)  
Brown, David E.  
520 Hume Mansur Bldg. (4)  
Brown, DeWitt W.  
920 Hume Mansur Bldg. (4)  
Brown, Edward A. (S)  
201 Fountain Sq. Th. Bldg. (3)  
Brown, Frances T.  
2126 N. Talbot (2)  
Brown, Wendell E.  
802 C. of C. Bldg. (4)  
Browning, James S.  
3209 N. Meridian (8)  
Browning, William M.  
3740 Central (5)  
Breutsch, Walter L.  
Central State Hospital (22)  
Buck, Charles E.  
I. U. Medical Center (7)  
Bunde, Carl A.  
Pitman-Moore Co. (6)  
Burdette, Harold F.  
3202 N. Meridian (8)  
Burghard, Rolla D.  
3760 N. Sherman Dr. (18)  
Burney, Leroy E.  
1330 W. Michigan (7)  
Butler, John O.  
1481 W. 10th St. (2)  
Butler, Robert M.  
3608½ E. 10th (1)  
Buttz, Rose J. P. . . 112 E. 13th (2)

## C

Cahal, Ernest . . . 2614 Shelby (3)  
Cahn, Hugo M. . . . 418 E. 30th (5)  
Caldwell, Marilyn. Riley Hosp. (7)  
Call, Herbert F.  
321 Hume Mansur Bldg. (4)  
Campbell, John A.  
I. U. School of Medicine (7)

## MARION COUNTY

(Indianapolis—Continued)

Canaday, James W. (S)  
1229 Prospect (3)  
Caplin, Irvin . . . 2033 N. Harding (2)  
Caplin, Samuel S. . . 111 E. 30th (5)  
Carlson, Charles E.  
Allison Div. G.M.C.  
Carson, Wayne  
1011 Hume Mansur Bldg. (4)  
Carter, James C.  
44 E. 57th St. (20)  
Carter, Oren E. . . . 668 E. 38th (5)  
Cayley, Frank J.  
Central State Hospital (22)  
Chattin, Wm. R. General Hosp. (7)  
Chen, Ko Kuei . . Eli Lilly & Co. (6)  
Christian, William A.  
1481 W. 10th St. (2)  
Chroniak, Walter  
5703 E. Washington St. (19)  
Clark, Cecil P.  
922 Hume Mansur Bldg. (4)  
Clark, Cyrus J. . . 6325 Guilford (20)  
Clark, Lawson J.  
3736 N. Delaware (5)  
Clevinger, William G.  
1610 Auburn St. (24)  
Close, W. Donald  
809 Hume Mansur Bldg. (4)  
Coble, Ralph R.  
3311 N. Meridian (8)  
Cohn, Alvin C. Methodist Hosp. (7)  
Collins, Hubert L.  
985 N. Arlington (19)  
Collins, James N.  
712 Hume Mansur Bldg. (4)  
Conley, Joseph L.  
2443 E. Washington (1)  
Conway, Chester C.  
4402 E. New York (1)  
Conway, Glenn . . 1620 S. East (25)  
Cook, Charles J. (S)  
2405 Carrollton (5)  
Copeland, Samuel J. (S)  
427 Bankers Trust Bldg. (4)  
Cornacchione, Matthew  
814 S. East (25)  
Cortese, James V. 435 S. East (25)  
Cortese, Thomas A.  
435 S. East (25)  
Courtney, John W.  
518 Hume Mansur Bldg. (4)  
Cox, Clifford E.  
R. R. 16, Box 593 (44)  
Cox, Harold B.  
5316 E. Washington (19)  
Craft, Kenneth L.  
1002 Hume Mansur Bldg. (4)  
Craven, Howard T.  
922 Hume Mansur Bldg.  
Crawford, John A.  
301 Hume Mansur Bldg. (4)  
Culbertson, Clyde G.  
Lilly Research Lab. (6)  
Cullen, Paul K.  
422 Hume Mansur Bldg. (4)  
Culloden, William G.  
710 E. 46th (5)  
Cunningham, John M. (S)  
508 Hume Mansur Bldg. (4)  
Cure, Charles W.  
914 Hume Mansur Bldg. (4)  
Cuthbert, Marvin  
607 Hume Mansur Bldg. (4)

## D

Daggy, James R.  
General Hosp. (7)  
Dailey, John E.  
3707 N. Meridian (8)  
Dalton, John E.  
707-708 Hume Mansur Bldg. (4)  
Dalton, William W.  
4205 Otterbein (27)  
Daniel, John C.  
1008 Hume Mansur Bldg. (4)  
Davidson, N. Cort  
3008 Clifton (23)  
Davis, John A. . . 2719 E. Mich. (1)  
Davis, Sam J.  
908 Hume Mansur Bldg. (4)  
Deal, Eleanor H. B.  
1544 Main St., Speedway (24)  
Dearmin, Robert M.  
3233 N. Meridian (8)  
DeArmond, Murray  
723 Hume Mansur Bldg. (4)  
Deever, John W. . . 4131 Shelby (3)  
DeMotte, C. Bowen  
808 C. of C. Bldg. (4)  
Denny, Forrest L.  
3351 W. 10th (22)  
Denny, James W.  
5504 E. Washington (19)  
Des Jean, Paul A.  
638 K. of P. Bldg. (4)  
DeWees, Dwight L.  
302 N. Bradley (1)  
Dilts, Robert Louis  
2521 E. 38th (18)  
Dintaman, Paul G.  
432 Bankers Trust Bldg. (4)  
Donato, Albert M. 1521 Shelby (3)  
Doran, J. Hal  
720 Hume Mansur Bldg. (4)  
Dorman, Willis L.  
5508 E. Washington (19)  
Dowd, Joseph A.  
6177 College (20)  
Drake, William L.  
General Hosp. (7)  
Dryden, Gale E. . . 1630 Montcalm  
Dugan, Thomas J. (S)  
2540 W. Washington (22)  
Dugan, William M.  
410 Hume Mansur Bldg. (4)  
Dunbar, Colin V.  
423-4 Hume Mansur Bldg. (4)  
Dulin, Basil B. . . 734 N. Bolton Ave.  
Dunning, Lehman M.  
1561 College (2)  
Dvorak, June A.  
I.U. Medical Center (7)  
Dyar, Edwin W.  
3202 N. Meridian (8)  
Dyke, Richard W.  
General Hospital (7)

## E

Earp, Evanson B.  
717 Hume Mansur Bldg. (7)  
Eastman, Joseph R., Jr.  
817 Merchants Bank Bldg. (4)  
Eaton, Edwin R.  
3120 N. Meridian (8)  
Ebert, J. Wayne . . 509 Lincoln (3)  
Eberwein, John H.  
414 E. Fall Ck. Pkwy., N. D. (5)  
Eckert, Russell A.  
20 Johnson Ave. (19)  
Egbert, Herbert L.  
504 Hume Mansur Bldg. (4)

Egbert, Roy  
2601 Roosevelt Ave. (18)  
Eicher, Palmer O.  
3209 N. Meridian (8)  
Eikenberry, Hugh W.  
616 Bankers Trust Bldg. (4)  
Eldridge, Gail E. . . 1440 E. 46th (5)  
Elliott, Roy H. (S)  
2430 E. 36th St. (5)  
Ellis, Bert E.  
303 Hume Mansur Bldg. (4)  
Emhardt, John T. 1621 S. East (25)  
Emhardt, John W. A.  
709 Underwriters Bldg. (4)  
Enslinger, L. A.  
908 Hume Mansur Bldg. (4)  
Enzor, Ora K. . . . 4216 College (5)  
Ernst, Clifford E.  
General Hosp. (7)  
Evans, Frederick H.  
4068 Byram (8)  
Evans, Paul V. . . General Hosp. (7)  
Everly, Ralph V. . . 4216 College (5)

## F

Failey, Robert B., Jr.  
420 Hume Mansur Bldg. (4)  
Farrell, Joseph T.  
2807 E. Michigan (1)  
Fausset, C. Basil  
2901 N. Meridian St. (8)  
Fisch, Charles  
3120 N. Meridian St. (8)  
Fisk, Frank B. . . 1200 Madison (6)  
Fitzgerald, William J.  
203 Ftn. Sq. Bldg. (3)  
Flanigan, Meredith B.  
2920 W. 33rd (22)  
Flick, John J. . . 1443 N. Penn. (2)  
Flora, Joseph O.  
4317 W. Washington (21)  
Folkening, Norval C.  
204 Ftn. Sq. Bldg. (3)  
Foreman, Harry L. . . 60 W. 30th (8)  
Forry, Frank  
I. U. Medical Center (7)  
Fosgate, Harold L.  
2123 W. Washington St. (22)  
Foster, Lee N.  
St. Vincent's Hosp. (7)  
Fouts, Paul J.  
522 Hume Mansur Bldg. (4)  
Franklin, William L.  
508 Hume Mansur Bldg. (4)  
Frazin, Bernard  
Billings VA Hospital  
Ft. Benj. Harrison (16)  
Friedman, David K.  
General Hosp. (7)  
Fromhold, Willis A.  
611 Bankers Trust Bldg. (4)  
Fry, Robert D.  
612 Hume Mansur Bldg. (4)  
Fullerton, Robert L. 3665 N. Ill. (8)  
Funkhouser, Arthur G.  
702 Underwriters Bldg. (4)  
Funkhouser, Elmer  
702 Underwriters Bldg. (4)  
Furgason, Paul C.  
1008 Hume Mansur Bldg. (4)  
Furniss, Sumner A. (S)  
834 N. West St. (2)

## G

Gabe, William E.  
612 Hume Mansur Bldg. (4)



## MARION COUNTY

## (Indianapolis—Continued)

Gaddy, Euclid T.  
2602 W. Washington (22)

Gallup, Palmer R.  
601 Inland Bldg. (4)

Gambill, William D.  
1019 Hume Mansur Bldg. (4)

Gammieri, Robert L.  
3326 Clifton (23)

Garber, J. Neill  
806 Hume Mansur Bldg. (4)

Garceau, George J.  
508 Hume Mansur Bldg. (4)

Gard, Daniel A. 1156 Lee St. (21)

Gardiner, Sprague H.  
314 Hume Mansur Bldg. (4)

Gardner, Buckman  
St. Vincent's Hospital (7)

Garfield, Martin D.  
3705 College (5)

Garner, William (H)  
2911 E. 10th (1)

Garner, W. Stanley  
2911 E. 10th (1)

Garrett, John D. (S)  
510 Doctors Bldg. (4)

Garrett, Robert A.  
I. U. Medical Center (7)

Gaskill, Herbert S.  
I. U. Medical Center (7)

Gastineau, David C.  
I. U. Medical Center (7)

Gastineau, Frank M.  
407 Hume Mansur Bldg. (4)

Gatch, W. D.  
605 Hume Mansur Bldg. (4)

Geider, Roy A. 1443 Prospect (3)

Genovese, Pasquale  
1481 W. 10th St. (2)

George, Charles L. 507 E. 34th (5)

Gibson, Maxine  
5744 Broadway Terrace (20)

Gick, Herman H.  
2705 E. Michigan (1)

Gifford, Fred E.  
710 Hume Mansur Bldg. (4)

Gillespie, Charles F.  
3209 N. Meridian (8)

Gillespie, Jacob E.  
523 Hume Mansur Bldg. (4)

Glass, Robert L.  
608 Hume Mansur Bldg. (4)

Glendening, John L.  
132 Insurance Bldg. (4)

Glendening, Richard L.  
Methodist Hosp. (7)

Goldman, Samuel 1266 Oliver (21)

Goodwin, Caroline J.  
1220 Pickwick Pl. (8)

Gosman, James H.  
2901 N. Meridian (8)

Graf, John P.  
I. U. Medical Center (7)

Graves, John W.  
949 Ellenberger Pky. E. Dr. (19)

Green, Harrison  
1011 Hume Mansur Bldg. (4)

Green, Oscar  
6203 Indianola Ave. (20)

Greene, Morgan E.  
1621 S. East St. (3)

Greist, John H.  
2901 N. Meridian St. (8)

Griffith, Richard S. Lilly Clinic (7)

Griffith, Ross E. 401 E. 34th (5)

Grisell, Ted L.  
504 Hume Mansur Bldg. (4)

Gustafson, Gerald W.  
314 Hume Mansur Bldg (4)

Gutelius, Charles B.  
3028 Park Ave. (5)

## H

Habich, Carl  
702 Hume Mansur Bldg. (4)

Hadley, David  
809 Hume Mansur Bldg. (4)

Hadley, Murray N. (S)  
809 Hume Mansur Bldg. (4)

Haggard, Edmund B.  
806 Board of Trade Bldg. (4)

Hahn, E. Vernon  
914 Hume Mansur Bldg. (4)

Hall, Frank M.  
141 S. Meridian St. (14)

Hall, Jack R. 3342 N. Illinois (8)

Hallam, F. Tulley  
1129 State Life Bldg. (4)

Hamer, Homer G.  
1711 N. Capitol (7)

Hampshire, Donald R.  
1443 N. Pennsylvania (2)

Hancock, John G.  
2226 W. Michigan (22)

Hanley, Edward J., Jr.  
615 Hume Mansur Bldg. (4)

Hanna, Thomas A.  
1608 N. Lynhurst Dr. (24)

Hansell, R. M. 7 N. Euclid (1)

Harcourt, Allan K.  
812 C. of C. Bldg (4)

Harding, M. Richard  
308 Hume Mansur Bldg. (4)

Harding, Myron S.  
308 Hume Mansur Bldg. (4)

Hare, Earl H.  
1481 W. 10th St. (2)

Hare, Laura  
404 Hume Mansur Bldg. (4)

Harold, Albert H. (S)  
7510 Allisonville Rd. (44)

Harold, Norris E. (S)  
3545 N. Denny St. (18)

Harris, Carl B.  
319 Hume Mansur Bldg. (4)

Harris, Paul N.  
Eli Lilly & Co. (6)

Hasewinkel, Carroll W.  
Methodist Hospital (7)

Haslinger, Clarence J.  
2151 E. New York (1)

Hatfield, B. F.  
802 C. of C. Bldg. (4)

Hatfield, Jack J.  
802 C. of C. Bldg. (4)

Hatfield, N. W. 2032 N. Rural (18)

Hawk, James H.  
514 Hume Mansur Bldg. (4)

Haymond, Joseph L.  
3769 College (5)

Hays, Everett L. Billings VA Hosp.,  
Ft. Benj. Harrison (16)

Hedrick, Philip W. 654 E. 54th (20)

Heinz, Dorothy C. V.  
1315 W. 10th St. (2)

Henderson, F. G. Eli Lilly & Co. (6)

Hendricks, J. D. (S)  
2230 N. Del. (5)

Hendricks, John W.  
911 Hume Mansur Bldg. (4)

Hennessee, Philip C.  
320 Hume Mansur Bldg. (4)

Henry, Russell S.  
725 Hume Mansur Bldg. (4)

Hepburn, C. K.  
524 Hume Mansur Bldg (4)

Hetherington, A. M.  
4121 E. New York (1)

Hetherington, John A.  
822 Hume Mansur Bldg. (4)

Heubi, J. E. 668 E. Maple Rd. (5)

Hickman, W. F. 1210 Oliver (21)

Hildrup, Don G.  
18 W. Georgia St. (4)

Himebaugh, James R. S.  
513 S. Sherman Dr. (3)

Himebaugh, James R. S.  
513 S. Sherman Dr. (3)

Himler, James M.  
809 Underwriters Bldg. (4)

Hine, U. B. 4808 E. Mich. (1)

Hines, Don C. Eli Lilly & Co. (6)

Hodges, Fletcher  
VA Regional Office (4)

Hoffman, Herman  
Hume Mansur Bldg (4)

Hofmann, J. William  
323 Hume Mansur Bldg. (4)

Hollingsworth, A. A.  
4032 E. Wash. (1)

Holman, J. E., Jr. 3315 E. 10th (1)

Holman, Jerome E., Sr.  
523 Bankers Tr. Bldg. (4)

Holsinger, Robert  
General Hospital (7)

Holtzman, Paul W.  
General Hosp. (7)

Hood, A. A. 5059 S. Harlan (44)

Horwitz, Thomas  
423-4 Hume Mansur Bldg. (4)

Houseworth, John H.  
1481 W. 10th St. (2)

Howell, Joseph D.  
760 Bankers Tr. Bldg. (4)

Howell, Robert D.  
900 Underwriters Bldg. (4)

Hoyt, L. H. Methodist Hosp. (7)

Huber, Carl P.  
I. U. Med. Center (7)

Hudson, F. J. 3440 N. Meridian (8)

Hughes, William F. (S)  
4025 N. Meridian St. (8)

Hull, James E.  
General Hospital (7)

Hummons, H. L. 729½ N. West (2)

Hurt, Laverne B.  
635 E. Kessler Blvd. (20)

Huse, William M.  
805 Hume Mansur Bldg. (4)

## I

Irwin, Glenn W., Jr.  
I. U. Med. Center (7)

Iske, Paul G.  
1015 Hume Mansur Bldg. (4)

## J

Jackson, Frederick E.  
510 Doctors Bldg. (4)

Jackson, James W.  
1330 W. Mich. (7)

Jackson, J. L. 3001 E. 10th (1)

Jacobs, Harry A.  
3859 Washington Blvd. (5)

Jaeger, A. S. (S)  
430 Bankers Tr. Bldg. (4)

Jaquith, Orville S. (S)  
261 Blue Ridge Rd. (8)

## MARION COUNTY

## (Indianapolis—Continued)

Jay, A. N. 3233 N. Meridian (8)  
 Jeffries, K. I. 807 Virginia (3)  
 Jenkins, R. E. 3311 N. Meridian (8)  
 Jennings, Frank L.  
 Sunnyside Sanatorium (44)  
 Jewett, J. H. 3120 N. Meridian (8)  
 Jewett, Laurence (S)  
 6497 Broadway (20)  
 Jewett, Robert E.  
 6497 Broadway (20)  
 Jinks, C. H. 4216 College (5)  
 Jobs, James E.  
 305 Traction Term. Bldg. (4)  
 Jobs, Norman E. (S)  
 305 Traction Term. Bldg. (4)  
 Johantgen, Harold N.  
 I.U. Medical Center (7)  
 Johnson, Thomas W.  
 529 Bankers Tr. Bldg. (4)  
 Johnson, W. F. 2121 N. Harding (2)  
 Jones, Allen W.  
 1481 W. 10th St. (2)  
 Jones, David E.  
 828 C. of C. Bldg. (4)  
 Jones, F. P. 4305 E. Michigan (1)  
 Joseph, R. M. 1615 S. East (25)

## K

Kahler, M. V. 2338 W. Mich. (22)  
 Kahn, A. J. 3120 N. Meridian (8)  
 Kahn, H. L. 3120 N. Meridian (8)  
 Kalb, E. L. 356 S. Emerson (19)  
 Kammen, Leo 3414 Clifton (23)  
 Kammen, Robt. 3202 W. 16th (22)  
 Katterjohn, James C.  
 313 Hume Mansur Bldg. (4)  
 Kauffman, Nelson N.  
 2901 N. Meridian St. (8)  
 Kauffman, Sidney A.  
 226 Hume Mansur Bldg. (4)  
 Keenan, R. L.  
 615 Hume Mansur Bldg. (4)  
 Keever, C. H. 5214 College (20)  
 Keiser, Venice D.  
 646 Bankers Tr. Bldg. (4)  
 Kelley, Clement E.  
 Methodist Hosp. (7)  
 Kelly, Don E.  
 702 Underwriters Bldg. (4)  
 Kelly, John F.  
 517 Hume Mansur Bldg. (4)  
 Kelly, Walter F. (S)  
 5503 E. Washington (19)  
 Kelly, W. M. 5438 E. Wash. (19)  
 Kempf, G. F. General Hospital (7)  
 Kendrick, W. M. 1829 E. 46th (5)  
 Kennedy, Hall 2152 N. Meridian (2)  
 Kennedy, H. F. 1105 Prospect (3)  
 Kenoyer, Wilbur L.  
 2139 College Ave. (2)  
 Kerr, H. R. 2817 E. Wash. (1)  
 Ketcham, Jane M.  
 514 Hume Mansur Bldg. (4)  
 Kilgore, B. W. 3133 E. 38th (18)  
 Kime, Edwin N.  
 711 Underwriters Bldg. (4)  
 King, William E.  
 811 Hume Mansur Bldg. (4)  
 King, W. F. (S) 1330 W. Mich. (7)  
 Kingsbury, John K.  
 5462 E. Washington (19)  
 Kinzel, Robert J. W.  
 3120 N. Meridian (8)

Kirkhoff, Paul J.  
 1517 N. Emerson (19)  
 Kirklin, Oren L.  
 202 Hume Mansur Bldg. (4)  
 Kirtley, William R.  
 Lilly Research Lab. (6)  
 Kiser, Edgar F.  
 226 Hume Mansur Bldg. (4)  
 Kitterman, Harry E.  
 510 Hume-Mansur Bldg. (4)  
 Klahr, Elsworth E.  
 General Hosp. (7)  
 Klain, B. V. 4157 College (5)  
 Knowles, C. Y.  
 Riley Hospital (7)  
 Knowles, Robert P.  
 2901 N. Meridian St. (8)  
 Kohlstaedt, George W.  
 422 Hume Mansur Bldg. (4)  
 Kohlstaedt, Karl C.  
 422 Hume Mansur Bldg. (4)  
 3660 W. 16th (2))  
 Kohlstaedt, Kenneth G.  
 General Hosp. (7)  
 Koons, Karl M.  
 922 Hume Mansur Bldg. (4)  
 Kopecky, R. R.  
 4131 Shelby St. (27)  
 Kornafel, L. H.  
 608 K. of P. Bldg. (4)  
 Kraft, Bennett  
 760 Bankers Tr. Bldg. (4)  
 Kuntz, Herman W.  
 501 Hume Mansur Bldg. (4)  
 Kurtz, Fred B.  
 5520 N. Illinois St. (8)  
 Kurtz, P. L. 668 E. 38th (5)  
 Kwitny, I. J. 3209 N. Meridian (8)

## L

LaDine, C. B. 2440 Station (18)  
 Lamb, Emmett B.  
 205 Hume Mansur Bldg. (4)  
 Lamb, Russell W.  
 205 Hume Mansur Bldg. (4)  
 Lamber, Chet K.  
 912 Hume Mansur Bldg. (4)  
 Langdon, Harry K. (S)  
 3264 N. Penn. (5)  
 Langdon, J. Ray 1800 E. 10th St.  
 Laramore, Ward  
 Billings VA Hosp. (16)  
 Larkin, Bernard J.  
 305 Hume Mansur Bldg. (4)  
 Lawler, G. F. 3934 E. 10th (1)  
 Lawrence, Edwin A.  
 I.U. Med. Center (7)  
 Leasure, J. Kent  
 611 Hume Mansur Bldg. (4)  
 Leatherman, Harter L.  
 1531 Broadway (2)  
 Leedy, Gladys J.  
 Central State Hospital (22)  
 Leff, Abe H. 712 E. 52nd (5)  
 Leffel, James M., Jr.  
 3209 N. Meridian (8)  
 Leffler, William T.  
 2141 E. 52nd St. (5)  
 Leonard, Henry S. (S)  
 303 Hume-Mansur Bldg. (4)  
 Leser, Ralph U.  
 3233 N. Meridian (8)  
 Levi, Leon 40 W. 38th (8)  
 Levin, R. T. 3209 N. Meridian (8)  
 Libbert, Edwin L.  
 VA Regional Office (4)  
 Lichtenberg, Melvin  
 535 E. 38th (5)

Lidikay, Edward C.  
 915 Hume Mansur Bldg. (4)  
 Lindenborg, Paul G.  
 1402 N. Olney (1)  
 Lingeman, Raleigh E.  
 411 Hume Mansur Bldg. (4)  
 Lingeman, Roger E.  
 4143 Blvd. Place (8)  
 Link, Goethe  
 608 Ind. Pythian Bldg. (4)  
 Linton, Charles D.  
 I. U. Medical Center (7)  
 Little, J. W. (S) 2735 E. 10th (1)  
 Little, William J.  
 1481 W. 10th St. (2)  
 Lochry, Ralph L.  
 St. Vincent's Hosp. (7)  
 Loehr, William M.  
 712 Hume Mansur Bldg. (4)  
 Long, William H. R. R. 2, Box 534  
 Loomis, Norman S.  
 5230 Kenwood (8)  
 Lord, G. C. 104 E. Maple Rd. (5)  
 Love, G. N.  
 1644 N. Delaware St. (2)  
 Ludwig, O. D. 5433 Madison (3)  
 Lurie, Paul R.  
 I. U. Medical Center (7)  
 Lybrook, William B.  
 3749 N. Keystone (18)

## M

McArt, Bruce A. General Hosp. (7)  
 McBride, James S.  
 810 Hume Mansur Bldg. (4)  
 McCallum, J. T. C. 237 W. 46th (8)  
 McCarthy, Daniel J. (S)  
 3055 N. Meridian (8)  
 McCartney, D. H.  
 918 Hume Mansur Bldg. (4)  
 McCaskey, Carl H.  
 608 Guaranty Bldg. (4)  
 McClain, Edwin S.  
 414 Hume Mansur Bldg. (4)  
 McCormick, C. O., Jr.  
 621 Hume Mansur Bldg. (4)  
 McCormick, C. O., Sr.  
 621 Hume Mansur Bldg. (4)  
 McCown, Percy E.  
 521 Hume Mansur Bldg. (4)  
 McDevitt, Daniel R.  
 3202 N. Meridian (8)  
 McGrath, M. F. 1929 E. 38th (18)  
 McGuff, P. E. 605 E. Maple Rd. (5)  
 McIntire, Clarence R.  
 3202 Meridian (8)  
 McIntyre, Charles J.  
 414 Hume Mansur Bldg. (4)  
 McIntyre, J. M.  
 2901 N. Meridian St. (8)  
 McKechnie, Franklin B.  
 I.U. Medical Center (7)  
 McKinley, A. David  
 I.U. Hospitals (7)  
 McMillan, Frederick G.  
 1110 Odd Fellows Bldg. (4)  
 McNamara, J. P. 5610 College (20)  
 McQuiston, Ralph J.  
 608 Guaranty Bldg. (4)  
 McTurnan, Robert W.  
 5646 N. Illinois (8)  
 Mackey, H. S. 4309 Central (5)  
 Mackey, J. H.  
 3209 N. Meridian St. (8)  
 Madtson, A. R.  
 822 Hume Mansur Bldg. (4)  
 Magennis, H. L. 468½ W. Wash. (4)



## MARION COUNTY

(Indianapolis—Continued)

Manalan, M. M.  
1481 W. 10th St. (2)

Manion, Marlow W.  
601 Hume Mansur Bldg. (4)

Mann, Mortimer  
323 Hume Mansur Bldg. (4)

Manning, J. C., Jr.  
1015 Hume Mansur Bldg. (4)

Manning, K. Randolph  
723 Hume Mansur Bldg. (4)

Marks, Maurice I.  
2901 N. Meridian St. (8)

Marshall, A. L., Jr.  
1330 W. Michigan St. (7)

Marshall, C. R. . . . 43 W. 30th (8)

Martin, H. E. . . . 1200 Madison (6)

Martin, L. H. . . . 2626 W. Wash. (22)

Martz, Bill L. . . . General Hosp. (7)

Martz, Carl D.  
508 Hume Mansur Bldg. (4)

Marvel, R. J. 3311 N. Meridian (8)

Masters, John M.  
805 Hume Mansur Bldg. (4)

Masters, Robert J.  
805 Hume Mansur Bldg. (4)

Matthew, W. Burleigh  
520 Hume Mansur Bldg. (4)

Matthews, B. J. . . . 4612 E. 10th (1)

Matthews, W. M. . . . 4612 E. 10th (1)

Mayer, Robert. General Hosp. (7)

Megenhardt, D. S.  
1015 Hume Mansur Bldg. (4)

Meiks, Lyman T. . . . Riley Hosp. (7)

Melloh, A. F. . . . 2821 E. 10th (1)

Mendenhall, Clarence D.  
4502 E. Wash. (1)

Mentendiek, Maurice H.  
205 Hume Mansur Bldg. (4)

Mericle, Earl W.  
920 Hume Mansur Bldg. (4)

Merrell, Paul  
914 Hume Mansur Bldg. (4)

Mertz, H. O. . . . 1711 N. Capitol (7)

Mertz, John H. O.  
1711 N. Capitol Ave. (7)

Micheli, Arthur J.  
920 Underwriters Bldg. (4)

Middleton, H. N. . . . 1828 N. Ill. (2)

Miller, J. Don  
514 Hume Mansur Bldg. (4)

Miller, John R. . . . 953 E. Tabor

Miller, R. S. . . . 6211 College (20)

Miller, Wallace E.  
510 Hume Mansur Bldg. (4)

Millikan, William J.  
3736 N. Delaware (5)

Mintz, Alfred M.  
I.U. Medical Center (7)

Mitchell, E. H. . . . 1023 King (22)

Mitchell, Edward O.  
5704 N. Keystone (20)

Modjeska, Gerald S.  
I.U. Medical Center (7)

Moening, Walter P.  
618 K. of P. Bldg (4)

Molt, William F. (S)  
529 Bankers Tr. Bldg. (4)

Montgomery, William F.  
311 Hume Mansur Bldg. (4)

Moore, Ben B.  
414 Hume Mansur Bldg. (4)

Moore, H. T. . . . 3220 N. Sharon (22)

Moore, Robert M.  
5617 N. Meridian St. (8)

Morchan, Saml. . . . 3769 College (5)

Morec, G. J. . . . General Hosp. (7)

Morgan, Margaret E.  
I.U. Medical Center (7)

Moriarty, John R.  
5602 Madison (3)

Morrison, Lewis E.  
603 Hume Mansur Bldg. (4)

Morton, Walter P.  
623 Hume Mansur Bldg. (4)

Moser, Rollin H.  
400 Hume Mansur Bldg. (4)

Moss, Bobby L.  
144 E. 22nd St. (2)

Moss, H. B. . . . 144 E. 22nd St. (2)

Moss, Herschel C.  
I.U. Medical Center (7)

Mothersill, M. H.  
3650 College Ave. (5)

Moulton, L. G. . . . 1327 N. Penn. (2)

Mozingo, Arvine E.  
1129 S. Meridian (25)

Mueller, L. B. . . . 4026 Broadway (5)

Muller, L. P. . . . 5608 College (20)

Muller, P. F. 3311 N. Meridian (8)

Mumford, E. B. 320 N. Meridian (4)

Myers, Chas. W. . . . R. 2, Box 249A

Myers, R. V. . . . 1904 N. Rural (18)

## N

Nafe, Cleon A.  
822 Hume Mansur Bldg. (4)

Nagan, Robert F.  
1434 N. Delaware (2)

Nay, Richard M.  
1007 Hume Mansur Bldg. (4)

Need, L. T. . . . 1927 S. Meridian (25)

Neier, O. C. (S) 5506 E. Wash. (19)

Nester, H. G.  
Room 307, City Hall (4)

Nie, Louis W.  
2901 N. Meridian St. (8)

Nielsen, Juul C.  
1315 W. 10th St. (2)

Noble, Thomas B., Jr.  
1008 Hume Mansur Bldg. (4)

Nolting, H. F. . . . 261 W. 40th (8)

Norman, Olin B.  
922 Hume Mansur Bldg. (4)

Norman, William H.  
908 Hume Mansur Bldg. (4)

Norris, Howard Lee  
704 Hume Mansur Bldg. (4)

Norris, Max S.  
I.U. Medical Center (7)

Nourse, M. H. 1711 N. Capitol (7)

Nugent, E. J. Allison Div. GMC (6)

## O

O'Brian, Earl J.  
336 Prospect St. (25)

Ochsner, H. C. Methodist Hosp. (7)

O'Dell, Thomas A.  
3627 N. Penn. St. (5)

O'Malley, Martha  
1330 W. Michigan St. (7)

Olvey, O. N. . . . 3769 Park Ave. (5)

Orders, Clark E.  
440 Bankers Tr. Bldg. (4)

Otten, Claude F.  
812 C. of C. Bldg. (4)

Ottinger, Ross C.  
912 Hume Mansur Bldg. (4)

Owen, John E.  
605 Hume Mansur Bldg. (4)

Owens, T. C. 2823 N. Meridian (8)

Owens, Walter L.  
I.U. Medical Center (7)

## P

Pandolfo, Harry 2206 Madison (25)

Parker, G. F., Jr.  
1517 N. Emerson (19)

Parker, J. F. . . . 1706 E. Wash. (1)

Parker, Portia 2226 W. Mich. (22)

Patton, M. T. . . . 107 W. 30th (8)

Paulissen, G. T. 741 Markwood (27)

Pearson, Lyman R.  
311 Hume Mansur Bldg. (4)

Pebworth, Aubrey C. (S)  
1625 W. Morris (21)

Peck, F. B. . . . 740 S. Alabama (6)

Peirce, J. D. . . . Eli Lilly & Co. (6)

Peltier, Hubert C.  
I.U. Medical Center (7)

Pennington, Walter E.  
214 Hume Mansur Bldg (4)

Permer, Erwin . . . 134 E. 30th (5)

Peters, R. J. D. . . . 3203 E. Mich. (1)

Petranoff, T. V. 3367 W. Mich. (22)

Pettijohn, Fred L. (S)  
2460 Central (5)

Pfaff, Dudley  
VA Regional Office (4)

Pfaff, John A. (S)  
703 Hume Mansur Bldg. (4)

Pfafflin, Charles A. (S)  
6046 Riverview (20)

Phelps, Stephen R.  
General Hosp. (7)

Pickett, Robert D.  
400 Hume Mansur Bldg. (4)

Pierce, William J.  
Methodist Hosp. (7)

Pilcher, Jack E.  
201 Hume Mansur Bldg. (4)

Plautz, Geraldine Z.  
820 N. Bradley (1)

Pollak, Lewis . . . 1602 N. Penn. (2)

Popplewell, Arvine G.  
Sunnyside Sanitarium

Porter, Dale. 1481 W. 10th St. (2)

Price, Francis W.  
2020 Madison Ave. (25)

Price, James O.  
906 Hume Mansur Bldg. (4)

Pryor, R. C. . . . 6111 College (20)

## Q

Quigley, Jos. B.  
R. R. 13, Box 725 (44)

## R

Rabb, Frank M.  
624 Hume Mansur Bldg. (4)

Rabb, H. S. . . . 3139 E. 10th (1)

Raber, Robt. M.  
408 Hume Mansur Bldg. (4)

Rader, George S.  
1010 Hume Mansur Bldg. (4)

Radigan, L. R. I.U. Med. Center (7)

Ralston, John D.  
6349 Guilford Ave. (20)

Ramsey, Frank B.  
201 Hume Mansur Bldg. (4)

Reed, Jewett V.  
820 C. of C. Bldg. (4)

Reed, Philip B. . . 1800 E. 10th (1)

Reed, Robert G. Jr.  
General Hospital (7)

Rees, R. C. . . . 6114 E. Wash. (19)

Reid, Chas. A. . . . 2445 Shelby (3)

Reisler, Simon  
318 Bankers Tr. Bldg. (4)

Rhodes, Theodore D.  
307 Hume Mansur Bldg. (4)

## MARION COUNTY

## (Indianapolis—Continued)

Rice, R. M. . . . 740 S. Alabama (6)  
 Rice, T. B. . . . 1330 W. Michigan St. (7)  
 Richardson, Thad T. . . . 513 S. Sherman Dr. (3)  
 Richter, Arthur B. . . . 720 Hume Mansur Bldg. (4)  
 Ricketts, J. W. . . . 2901 N. Meridian St. (8)  
 Ridgeway, O. W. . . . 411 E. 16th (2)  
 Ridgway, Alton H. . . . I. U. Medical Center (7)  
 Rigg, John F. . . . 421 Hume Mansur Bldg. (4)  
 Rinker, Earl B. . . . 22 E. 57th St.  
 Ritchey, James O. . . . 608 Hume Mansur Bldg. (4)  
 Ritter, Wayne L. . . . 404 Hume Mansur Bldg. (4)  
 Robb, John A. . . . 238 Hume Mansur Bldg. (4)  
 Robertson, R. B. 6118 E. Wash. (19)  
 Rogers, Donald L. . . . 3311 N. Meridian St. (8)  
 Rohn, Robert J. . . . 420 Hume Mansur Bldg. (4)  
 Roller, C. W. . . . 1437 Shelby (3)  
 Romberger, F. T., Jr. . . . 3440 N. Meridian (8)  
 Rosenak, Bernard D. . . . 226 Hume Mansur Bldg. (4)  
 Rosenbaum, David . . . 1481 W. 10th St. (2)  
 Rosenbaum, Irving, Jr. . . . 401 E. 34th St. (5)  
 Ross, A. T. . . . I.U. Med. Center (7)  
 Roth, Bertram . . . 6378 College Ave. (20)  
 Row, D. Hamilton . . . 906 Hume Mansur Bldg. (4)  
 Rubin, Gerald S. . . . 624 Hume Mansur Bldg. (4)  
 Ruddell, Karl R. . . . 3202 N. Meridian (8)  
 Ruddell, Keith R. . . . 3202 N. Meridian (8)  
 Rudesill, Cecil L. . . . 405 Hume Mansur Bldg. (4)  
 Rudolph, Stephen J., Jr. . . . 1638 N. Meridian (2)  
 Rupel, Ernest . . . 419 Hume Mansur Bldg. (4)  
 Rust, B. K. . . . 3740 Central (5)  
 Ruth, M. L. . . . 4304 E. Wash. (1)  
 Rutherford, C. W. (S) . . . 4601 N. Penn. (5)  
 Ryan, G. V. . . . 2428 W. 16th (22)

## S

Sacks, Harry J. 1481 W. 10th (2)  
 Sage, Russell A. . . . 505 Hume Mansur Bldg. (4)  
 Salb, Max C. 826 C. of C. Bldg. (4)  
 Salzman, Morris . . . 1119 S. Meridian (25)  
 Sanders, Harry M. . . . 3760 N. Sherman Dr. (18)  
 Sandorf, Marvin 1102 Prospect (3)  
 Schaefer, C. Richard (S) . . . 224 N. Meridian, No. 20 (4)  
 Schechter, John S. . . . 3209 N. Meridian (8)  
 Scheier, E. W. . . . 1542 Prospect (3)  
 Schlaegel, T. F., Jr. . . . 624 Hume Mansur Bldg. (4)

Schmidt, L. F. . . . 605 Hume Mansur Bldg. (4)  
 Schmidt, R. H. Methodist Hosp. (7)  
 Schneider, C. J. 1008 N. Beville (1)  
 Schuchman, Abe . . . 5878 Washington Blvd. (20)  
 Schuchman, Gabriel . . . 3451 College (5)  
 Schuster, Dwight W. . . . 723 Hume Mansur Bldg. (4)  
 Scott, Geo. . . . 3340 N. Meridian (8)  
 Scott, I. W. . . . 3209 N. Meridian (8)  
 Scott, John R. . . . 510 E. 38th (5)  
 Scott, R. P. St. Vincent's Hosp. (7)  
 Scott, S. L. . . . 6325 Guilford Ave. (20)  
 Seaman, Charles F. . . . 1010 Hume Mansur Bldg. (4)  
 Sedam, H. L. . . . 4173½ College (5)  
 Segar, Louis H. . . . 226 Hume Mansur Bldg. (4)  
 Seitz, Philip F. D. . . . I.U. Med. Center (7)  
 Sexson, H. T. . . . 1301 College (2)  
 Shafer, Marion R. . . . 614 Hume Mansur Bldg. (4)  
 Sheehan, F. G. 5503 E. Wash. (19)  
 Sherster, H. 1135 S. Meridian (25)  
 Shrigley, Edward W. . . . I.U. Med. Center (7)  
 Shugart, Joseph A. . . . St. Vincent's Hosp. (7)  
 Shullenberger, W. A. . . . 3740 Central (5)  
 Shumacker, Harris B., Jr. . . . I.U. Med. Center (7)  
 Sicks, Okla W. . . . 606 Hume Mansur Bldg. (4)  
 Sidebottom, Earl . . . 606 Hume Mansur Bldg. (4)  
 Siekerman, C. W. 2614 Madison (3)  
 Siersdorfer, Theodore N. . . . 6003 W. Wash. (21)  
 Sigmond, Harvey W. . . . 301 Hume Mansur Bldg. (4)  
 Silver, Richard A. . . . I.U. Medical Center (7)  
 Simms, J. Leon . . . 2638½ Northwestern (23)  
 Simpson, W. D. . . . 6104 E. 21st (18)  
 Sims, J. Lawrence . . . 809 Hume Mansur Bldg. (4)  
 Sluss, D. H. . . . 808 C. of C. Bldg. (4)  
 Sluss, John W. (S) . . . 808 C. of C. Bldg. (4)  
 Smith, D. J. . . . 817 Hume Mansur Bldg. (4)  
 Smith, David L. . . . 2901 N. Meridian St. (8)  
 Smith, E. Rogers . . . 822 Hume Mansur Bldg. (4)  
 Smith, F. C. 983 N. Arlington (19)  
 Smith, Jas. M. . . . 600 Terminal Bldg. (4)  
 Smith, Jay W. . . . Eli Lilly & Co. (6)  
 Smith, Lester A. . . . 238 Hume Mansur Bldg. (4)  
 Smith, Roy Lee . . . 707 Underwriters Bldg. (4)  
 Smith, W. F. . . . 3424 College (5)  
 Smith, William B. . . . 2229 Northwestern (23)  
 Snider, Byron . . . 2717 S. East (3)  
 Solomon, Reuben A. . . . 414 Hume Mansur Bldg. (4)  
 Souter, M. C. 3360 N. Meridian (8)

Sovine, J. W. . . . 720 Hume Mansur Bldg. (4)  
 Spahr, John F., Jr. . . . 902 Hume Mansur Bldg. (4)  
 Spalding, Joseph J. . . . 706 Hume Mansur Bldg. (4)  
 Sparks, Alan L. . . . 1024 Hume Mansur Bldg. (4)  
 Spink, Urbana . . . 112 E. 13th (2)  
 Spivey, R. J. . . . 2616 N. Penn. (5)  
 Spolyar, L. W. . . . 1330 W. Mich. (7)  
 Spath, Carl B., Jr. . . . 301 Doctors Bldg. (4)  
 Spath, Carl B., Sr. . . . 301 Doctors Bldg. (4)  
 Stadler, H. E. . . . 5508 E. Wash. (19)  
 Stanley, J. S. . . . 307 City Hall (4)  
 Stayton, Chester A., Jr. . . . 313 Hume Mansur Bldg. (4)  
 Stayton, Chester A., Sr. . . . 313 Hume Mansur Bldg. (4)  
 Stephens, D. E. 6332 Guilford (20)  
 Stephens, K. H. . . . 501 Hume Mansur Bldg. (4)  
 Stern, Nathan . . . 601 Bankers Tr. Bldg. (4)  
 Stevens, S. L. . . . 303 Hume Mansur Bldg. (4)  
 Sthair, Phillip L. . . . General Hospital (7)  
 Stoelting, V. K. . . . I.U. Med. Center (7)  
 Stone, A. T. . . . 6202 College (20)  
 Stone, David F. . . . 725 Hume Mansur Bldg. (4)  
 Storey, D. Edmund . . . 813 Broad Ripple Ave. (20)  
 Storey, Jos. L. . . . 3434 N. Ill. (8)  
 Storms, Roy B. . . . 1014 Roosevelt Bldg. (4)  
 Stout, Francis E. . . . I.U. Med. Center (7)  
 Strange, Dempsey C. . . . 3509 N. Layman (18)  
 Stroup, T. J. 216 K. of P. Bldg. (4)  
 Stucky, E. K. . . . 1349 Madison (25)  
 Study, Robert S. . . . General Hosp. (7)  
 Stump, Thomas A. . . . 1413 Roache (23)  
 Stygall, James H. . . . 1221 N. Delaware (2)  
 Sudranski, Herbert F. . . . 624 Hume Mansur Bldg. (4)  
 Sutton, William E. . . . 419 Hume Mansur Bldg. (4)  
 Swan, John R. . . . 915 Hume Mansur Bldg. (4)  
 Swayne, J. F. . . . 1410 E. Wash. (1)  
 Symmes, Alfred T. . . . 605 E. Maple Rd. (5)  
 Szynal, Jno. S. 633 E. 38th St. (5)

## T

Talbott, Dan E. . . . 1020 Hume Mansur Bldg. (4)  
 Tanner, Henry S. . . . 301 Hume Mansur Bldg. (4)  
 Taube, Jack I. . . . 512 Hume Mansur Bldg. (4)  
 Taylor, Clifford C. . . . St. Vincent's Hosp. (7)  
 Taylor, Frederic W. . . . 400 Hume Mansur Bldg. (4)  
 Teague, Frank W. . . . 918 Hume Mansur Bldg. (4)



## MARION COUNTY

(Indianapolis—Continued)

Teixler, Victor A.  
224 Hume Mansur Bldg. (4)

Test, Charles E.  
1002 Hume Mansur Bldg. (4)

Test, Pasquale S.  
General Hosp. (7)

Teter, George V. . . . 401 E. 34th (5)

Tether, J. E. . . . I.U. Med. Center (7)

Tharp, Harold R.  
Methodist Hosp. (7)

Tharpe, Ray. . . . 3202 N. Meridian (8)

Thatcher, Hugh K., Jr.  
110 W. Maple Rd. (8)

Theye, Richard A.  
3223 Broadway (5)

Thom, J. W. . . . VA Reg. Office (4)

Thom, Julia S. . . . VA Reg. Office (4)

Thomas, Edw. P.  
820 W. Michigan St.

Thomas, Fred A.  
St. Vincent's Hosp. (7)

Thomas, L. I.  
1008 Hume Mansur Bldg. (4)

Thomas, Morris E.  
445 N. Penn., No. 715 (4)

Thomas, Ralph G. . . Gen. Hosp. (7)

Thompson, Charles F.  
818 Hume Mansur Bldg. (4)

Thompson, John V.  
1221 N. Delaware (2)

Thompson, Paul D.  
404 Hume Mansur Bldg. (4)

Thornburg, Kenneth E.  
1015 Hume Mansur Bldg. (4)

Thornton, H. C.  
3769 College Ave. (5)

Thrasher, John R.  
823 C. of C. Bldg. (4)

Thurston, H. S. (S)  
2503½ Prospect (3)

Tindall, George T.  
6002 Windsor Drive (18)

Tinney, William E.  
900 Underwriters Bldg. (4)

Tinsley, Frank W.  
603 K. of P. Bldg. (4)

Tinsley, Walter B.  
603 K. of P. Bldg. (4)

Tischer, E. Paul  
208 Hume Mansur Bldg. (4)

Topek, Nathan H. . . Gen. Hosp. (7)

Torrella, J. A. . . . 5324 W. 16th (24)

Toumey, Fred L.  
529 Bankers Tr. Bldg. (4)

Trusler, Harold M.  
408 Hume Mansur Bldg. (4)

Tuchman, J. H. . . . 845 Grove (3)

Tucker, R. L. . . . Eli Lilly & Co. (6)

Tucker, Warren S.  
414 Hume Mansur Bldg. (4)

Tyner, Harlan H.  
3202 N. Meridian St. (8)

## V

Vandivier, Robert M.  
209 Hume Mansur Bldg. (4)

Van Dorn, Myron J.  
3626 Clifton (23)

Van Fleet, Josephine  
I.U. Med. Center (7)

Van Meter, C. P. . . 3419 E. 10th (1)

Van Nuys, John D.  
I.U. Med. Center (7)

Van Osdol, Harry A.  
828 C. of C. Bldg. (4)

Van Vactor, Helen D.  
226 Hume Mansur Bldg. (4)

Vollrath, V. J. . . . 5202 N. Ill. (8)

Voyles, Charles F. (S)  
715 Underwriters Bldg. (4)

## W

Waldo, J. Thayer  
610 Hume Mansur Bldg. (4)

Walker, Frank C.  
414 Hume Mansur Bldg. (4)

Walker, Robt. K. . . 413 E. 34th (5)

Walther, J. E. 3202 N. Meridian (8)

Ward, Joseph H.  
2116 Boulevard Pl. (2)

Ward, W. C. . . . 116 E. 49th (5)

Warfel, F. C.  
VA Regional Office (9)

Warman, Alvah P.  
1363 E. 38th St. (5)

Warriner, James B.  
975 N. Emerson Ave. (19)

Warvel, John H.  
614 Hume Mansur Bldg. (4)

Waymire, E. S. . . . 1827 College (2)

Wehrman, Jule O. (S)  
504 Hume Mansur Bldg. (4)

Weigand, C. G. 740 S. Alabama (6)

Weil, H. J. . . . 443 N. Hamilton (1)

Weinland, George C.  
2934 E. 39th St. (5)

Weiss, Jason. . . 4914 W. 16th (24)

Weller, Charles A.  
3720 N. Delaware St.

West, Jos. L. . . . 6318 W. Wash. (21)

Westfall, B. K. . . 2901 E. 38th (18)

Westfall, John B.  
2961 N. Sherman Dr. (18)

Weyerbacher, A. F.  
663 E. 27th St. (5)

White, Donald J.  
502 Bankers Tr. Bldg. (4)

White, John B.  
812 C. of C. Bldg. (4)

Whitehead, John M.  
1544 Roosevelt (1)

Wilkens, I. W. . . . 1743 Shelby (3)

Williams, Chas. D. 2405 Station (1)

Williams, Clifford L.  
Central State Hospital

Williams, Howard S.  
115 E. 16th St. (2)

Williams, Hugh L.  
812 C of C Bldg. (4)

Wilson, Douglas E.  
I.U. Med. Center (7)

Wilmore, Ralph C.  
I.U. Med. Center (7)

Wilson, Fred M.  
I.U. Medical Center (7)

Wilson, John W.  
I.U. Med. Center (7)

Wilson, O. R. 3519 Wash. Blvd. (5)

Winters, Matthew. 508 E. 38th (5)

Wise, Wm. . . . 120 E. 22nd (2)

Wishard, Wm. Niles, Jr.  
1711 N. Capitol (7)

Wolfram, Don J.  
208 Hume Mansur Bldg. (4)

Wood, D. E. . . . 6325 Guilford (20)

Woodall, Earl C.  
3426 N. Meridian (8)

Woodard, A. S., Jr.  
668 E. Maple Rd. (5)

Worley, J. P. . . . 5831 E. Wash. (19)

Worley, Richard H.  
5925 E. Washington St. (19)

Wright, J. William, Jr.  
301 Hume Mansur Bldg. (4)

Wright, J. William, Sr.  
301 Hume Mansur Bldg. (4)

Wytenbach, F. C. . . 1154 Lee (21)

Wytenbach, John E.  
503 Hume Mansur Bldg. (4)

## Y

Young, John E.  
812 C. of C. Bldg. (4)

Young, J. M. 3209 N. Meridian (8)

Young, J. W. . . 6302 Guilford (20)

Young, W. C.  
428 Bankers Trust Bldg. (4)

## Z

Zaiac, Donald A.  
General Hosp. (7)

Zell, E. H. . . 812 C. of C. Bldg. (4)

Zerfas, C. P. A. . . 2605 Shelby (3)

Zerfas, Phyllis K. . 2605 Shelby (3)

Bartle, James L. . . . Lawrence

Lewis, Robert J. . . . Lawrence

Asher, E. O. . . . New Augusta

Asher, James W. . . . New Augusta

Paynter, Morris B. . . . Southport

Jones, George L. . . . Wanamaker

Berton, William M.  
887 Louise Circle, Durham, N.C.

Caseley, Donald J.  
922 E. 84th St., Chicago, Ill.

Connerly, Marion L.  
U. S. Naval Hosp.,  
San Diego, Calif.

Countryman, Frank W.  
Winter VA Hosp., Topeka, Kan.

Cusack, Robert  
327 Wilshire Blvd., Santa Monica,  
Calif.

Dester, Herbert E.  
Jagdeeshpur Via Raipur,  
C. P. India

Donner, Paul G.  
Hartford Retreat, Hartford, Conn.

Duckworth, Alda G.  
Johns Hopkins, Baltimore, Md.

Fisher, Gerald  
1120 Chester Ave., Cleveland 14, O.

Graf, John E. . . 4332 N. Kilbourn  
Ave., Chicago 41, Ill.

Griswold, Wait Robbins  
U. S. Naval Hosp.,  
Mare Island, Calif.

Gunderson, Shaun D.  
5120 Leavenworth St., Omaha,  
Neb.

Harger, Robert W.  
73 Galveston St., S.W.,  
Washington, D.C.

Harvey, Verne K.  
39 River Road Terrace,  
Alexandria, Va.

Hull, Roland H.  
U.S. Naval Hosp., Portsmouth, Va.

Kopp, Herschel S. . . . 3069 Calle  
Pinon, Santa Barbara, Calif.

MacDonnell, Thomas M.  
Marshfield, Mo.

Littlefield, Paul A.  
A.P.O. 301, San Francisco, Calif.

Lomax, Claude C.  
276 Santa Isabel, Costa Mesa, Calif.

MacDonald, John A. (S)  
Interlaken, N. Y.

**MARION COUNTY**

(Indianapolis—Continued)

Myers, Paul W.  
845 Fern, Fresno, Calif.

Mitchell, Raymond E.  
O'Reilly Veterans Hosp.,  
Springfield, Mo.

Murray, James S. 606 N. Roxbury,  
Beverly Hills, Calif.

Norwick, Sydney S.  
15816 Via Riveria,  
San Lorenzo, Calif.

Osborne, Harry S.  
R. 1, Box 337, Leesburg, Fla.

Pontius, Edwin E.  
Huntington Towers Center,  
Alexandria, Va.

Ritchey, Hardin  
Silver Hills Foundation  
New Canaan, Conn.

Rogers, Thomas P.  
U.S.N. Hosp., Philadelphia, Pa.

Rothenberger, Daniel J.  
Walker Air Base, Roswell, N.M.

Rudesill, Robert L.  
Mayo Clinic, Rochester, Minn.

Schimmelpfennig, Robert W.  
Children's Mercy Hospital  
Kansas City, Mo.

Seagle, William C.  
March Air Base, Riverside, Calif.

Seidell, Martin A.  
Mayo Clinic, Rochester, Minn.

Soper, Hunter A. 1605 E. 7th St.,  
Emmettsburg, Iowa

Tetrick, Elbert L.  
1726 Orrington Ave., Evanston,  
Ill.

Van Tassel, Charles J.  
Santa Ynez, Calif.

White, Philip T.  
Mayo Clinic, Rochester, Minn.

Whitt, James D.  
Baroness Erlanger Hosp.,  
Chattanooga, Tenn.

Winterhoff, Ernest H.  
368 E. Madison, Springfield, Ohio

Yochem, August S.  
U.S.N. Hosp., Chelsea, Mass.

Zeps, E. Frances  
Iowa State Univ. Hospital,  
Iowa City, Iowa

Ziperman, H. Haskell  
12A Clover Hill Gardens,  
Mt. Holly, N. J.

**MARSHALL COUNTY**

Kelly, Frank.....Argos

Sheller, Thomas G.....Argos

Connell, Vactor O.....Bourbon

Marshall, George L.....Bourbon

Bowen, Otis.....Bremen

Burket, Cecil R.....Bremen

Cripe, Earl P.....Bremen

Schreiner, John E.....Bremen

Bills, L. F.....R.R. 1, Culver

Witham, Robert L.....Culver

Connell, Paul S.....Plymouth

Irey, Paul R.....Plymouth

Kaler, James.....Plymouth

Klingler, Maurice O.....Plymouth

Kubley, James.....Plymouth

Pomeroy, Rex K.....Plymouth

Robertson, James S.....Plymouth

Vore, L. W.....Plymouth

Thompson, Alfred A.....Tyner

**MARTIN COUNTY**

(See Daviess-Martin)

**MIAMI COUNTY**

Shrock, Ethan E.....Amboy

Line, Homer E.....Chili

Frybarger, Samuel S.....Converse

Malott, Frederick R.....Converse

Sennett, Wm. K.....Macy

Waite, Earl L. Gilead Mail Macy

Rendel, Harold E.....Mexico

Barnett, Ralph E.....Peru

Berkebile, John B.....Peru

Burrous, E. L.....Peru

Carlson, E. A. (S).....Peru

Ferrera, Donald W.....Peru

Ferrara, Samuel J.....Peru

Herd, C. R.....Peru

Johnson, Owen.....Peru

Lynn, Frank M. (S).....Peru

Malouf, Stephen D.....Peru

Wildman, Roscoe E.....Peru

Yarling, John E. (S).....Peru

**MONROE COUNTY**

(See Owen-Monroe)

**MONTGOMERY COUNTY**

Crawfordsville

Alexander, Stephen J.  
306 Ben Hur Bldg.

Ball, T. Z. (S)  
403 Ben Hur Bldg.

Burks, Jess Edwin  
403 Ben Hur Bldg.

Cooksey, Thomas L. (S)  
109½ S. Washington St.

Cornell, Robert A.  
219 Ben Hur Bldg.

Daugherty, Fred N. 120 W. Pike St.

Dodds, Wemple...Culver Hospital

Haller, Thomas C.  
411 Tinsley Ave.

Humphreys, John W.  
312 Jones Ave.

Kinnaman, Howard A.  
206 Ben Hur Bldg.

Kirtley, James M.  
416 Ben Hur Bldg.

Lingeman, Byron N.  
419 Ben Hur Bldg.

Mount, Wm. M. 413 Ben Hur Bldg.

Peacock, Norman F.  
219 Ben Hur Bldg.

Pierson, Robert H. 305 E. Main St.

Pollom, Robt.....306 S. Water St.

Sharp, John L. 219 Ben Hur Bldg.

Wallace, Hawthorne C.  
419 Ben Hur Bldg.

Otten, Ralph E.....Darlington

Blix, Fred M.....Ladoga

Denny, Frank T.....Ladoga

Davis, William.....New Market

Kindell, Hurschell D.  
New Richmond

Hendrix, Claude A.....Waveland

Johnson, Frank D.....Waynetown

Parker, Carl B.....Wingate

**MORGAN COUNTY**

Alexander, P. M.....Martinsville

Bothwell, Camden G...Martinsville

Eisenberg, David A...Martinsville

Farr, James C.....Martinsville

Gibbs, Joseph W.....Martinsville

Gray, Leon.....Martinsville

Miller, Ray D.....Martinsville

Pitkin, Edward M.....Martinsville

Pitkin, McKendree C. Martinsville

Willan, Horace R.....Martinsville

Murphy, Maurice G...Morgantown

Comer, Charles W.....Mooresville

Comer, Kenneth E....Mooresville

Karpel, Bernard.....Mooresville

VanBokkelen, Robert W.  
Mooresville

**NEWTON COUNTY**

(See Jasper-Newton)

**NOBLE COUNTY**

Bowman, Charles M. .... Albion

Morr, John W. (S) .... Albion

Nash, Justin R. .... Albion

Sneary, Kenneth D. .... Avilla

Veazey, Wm. M. (S) .... Avilla

Bryan, Robert E. .... Kendallville

Goodwin, Columbus B. (S)  
Kendallville

Gutstein, Richard R... Kendallville

Lawson, Isaac H. .... Kendallville

Messer, Frank W..... Kendallville

Munk, Cleorie E. .... Kendallville

Seybert, Joseph D. .... Kendallville

Williams, Harold O... Kendallville

Young, Simon J. (S) . Kendallville

Harlin, Wm. L. .... Ligonier

Schutt, James B. .... Ligonier

Stultz, Quentin F. .... Ligonier

Webster, Paul L. .... Ligonier

Fipp, August L. .... Rome City

Pulskamp, Bertrand H.  
Wolcottville

Luckey, Harold A. .... Wolf Lake

Luckey, Robert C. .... Wolf Lake

Roth, James R. .... Wolf Lake

Switzer, Robert E.  
U.S. Naval Hosp., Bethesda, Md.

Fair, John R.  
1011 Peachtree St., Augusta, Ga.

**OHIO COUNTY**

(See Dearborn-Ohio)

**ORANGE COUNTY**

Keseric, Nicholas E... French Lick

Sugarman, Benj. E... French Lick

Take, John F. (S) ... French Lick

Colglazier, Granville G... Leipsic

Baker, Robert E. (S) ... Orleans

Hodgin, Philip.....Orleans

Schoofield, Wm. E.....Orleans

Clark, Ivan A.....Paoli

Hammond, Keith.....Paoli

Spears, John K.....Paoli

Teaford, Schuyler F. (S) ... Paoli

Boyd, Clarence E.... West Baden

Miller, Henderson L. (S)  
West Baden



**OWEN-MONROE  
COUNTIES****Bloomington**

Austin, Fred H. (S) .110 E. 4th St.  
Baxter, Neal E. . . . .306 E. 5th St.  
Bidney, Evelyn B. .214 E. Kirkwood  
Borland, Raymond M.

114 N. Lincoln St.  
Buckingham, Richard E.

344 College Ave.  
Culmer, Walter N. (S)

432 S. College Ave.  
Dalton, Naomi L. . . . .114 E. 7th St.  
DeMotte, Russell . . .403 N. Walnut  
Estes, Ambrose C. .300½ E. 5th St.  
Fowler, Richard R.

108 S. Washington  
Geiger, Dillon D. . .300 E. Kirkwood  
Hardtke, Eldred F.

Indiana University  
Hepner, Herman S. .312 N. Walnut  
Holland, Charles E.

712 N. Washington St.  
Holland, Deward J.

313 N. College Ave.  
Holland, Philip T. . .108 W. 7th St.  
Karsell, William A.

306 East Kirkwood  
Luzadder, John E. (S)

123½ W. 5th St.  
Lyons, Robert E. . . .321 E. 5th St.  
Marchant, Clarence H.

350 S. College  
McLelland, Mary Rhamy . .R.R. 2  
Middleton, Thos. O. . .404 E. 7th St.  
Miller, Mary E. . . . .701 E. 10th St.  
Owen, Abraham M.

200 S. Washington St.  
Owen, Margaret A.

200 S. Washington St.  
Pizzo, Anthony .Bloomington Hosp.  
Poolitson, George C.

407 N. Walnut St.  
Prosser, William O. H.

1211 E. Maxwell Lane  
Quarles, E. Bryan . . .Indiana Univ.  
Ramsey, Hugh S. . . . .307 E. 5th St.  
Reed, William C. . . . .307 E. 5th St.  
Rogers, Otto F., Jr.

210 N. Washington St.  
Rogers, Robert C. (S)

210 N. Washington St.  
Ross, Ben R. . . . .314 E. 7th St.  
Schell, Harry D. . . . .114 E. 4th St.  
Schuman, Edith B.

Indiana University  
Sibbitt, Joseph W. . . .300 E. 5th St.  
Smith, Herschel S.

110 S. Lincoln  
Smith, Paul E. . . . .812 North College  
Smith, Rodney D. (S)

115 N. Washington St.  
Spencer, Beaufort A.

114 N. Lincoln  
Stangle, William J.

Bloomington Hospital  
Topolugus, James N.

403 N. Walnut St.  
Tripp, Harry D. . . . .205 S. Walnut St.  
Wellpott, Jean Franklin

Indiana University  
Wilson, Talmage L.

301 E. Kirkwood

Brown, Frederick R. . . .Ellettsville  
Stouder, Charles E. . . . .Gosport

Mitchell, George L. . . . .Smithville  
Brown, Marcel S. . . . .Spencer  
Greene, Claude D. . . . .Spencer  
Kay, Oran E. . . . .Spencer  
Smith, Frederick R. . . . .Spencer

**PARKE-VERMILLION  
COUNTIES**

Greene, Frederick G. .Bloomingtondale  
Brown, Ralph E. . . . .Cayuga  
Darroch, Samuel . . . . .Cayuga  
Casebeer, Paul B. . . . .Clinton  
Evans, Frederick . . . . .Clinton  
Gerrish, Wakefield D. . . . .Clinton  
Kercheval, John M. . . . .Clinton  
Rosenfeld, Norman M. . . . .Clinton  
White, Isaac D. (S) . . . . .Clinton  
Lauer, Dorothy B. . . . .Dana  
Myers, William C. . . . .Dana  
Britton, Welbon D. . . .Montezuma  
Poda, George A.

Ordinance Plant, Newport  
Saunders, Jones L. . . . .Newport  
Johnson, William A. . . .Perrysville  
Bloomer, Joseph R. . . . .Rockville  
Bloomer, Richard S. . . . .Rockville  
Dowell, Emil H. . . . .Rockville  
Harstad, Casper . . . . .Rockville  
Merrell, Basil M. . . . .Rockville  
Pirkle, Hubert B.

Ind. State Sanitarium, Rockville  
Schaie, Milton

Ind. State Sanitarium, Rockville  
Staff, Robert A.

Ind. State Sanitarium, Rockville  
White, Chester S. . . . .Rosedale  
Keith, Freeman E. (S) . .St. Bernice

**PERRY COUNTY**

Bush, Hargis R. . . . .Cannelton  
Coultras, Porter J. . . . .Tell City  
Dome, Hardin S. (S) . . .Tell City  
Dukes, David . . . . .Tell City  
Glenn, Fred C. . . . .Tell City  
James, Nicholas A. . . . .Tell City  
Lashley, Donald L. . . . .Tell City  
Lohoff, Lewis C. . . . .Tell City  
Neifert, Noel L. . . . .Tell City  
Snyder, Earl R. . . . .Troy

**PIKE COUNTY**

Dickinson, Gordon A. . .Petersburg  
Higgins, James L. . . . .Petersburg  
Kime, John T. (S) . . . .Petersburg  
Logan, Austin R. (S) . . .Petersburg  
Omstead, Milton . . . . .Petersburg  
Rice, Thompson R. (S) . .Petersburg  
DeTar, George B. (S) . . .Winslow  
Dierdorf, Fred . . . . .Winslow

**PORTER COUNTY**

Dale, Joseph W. . . . .Chesterton  
Griffin, Joseph P. . . . .Chesterton  
Hall, Thomas C. . . . .Chesterton  
Harless, Clarence M. . . .Chesterton  
Robertson, William C. . .Chesterton  
Kleinman, Francis J. . . .Hebron  
Dittmer, Jack E. . . . .Kouts  
Brown, James C.

Farmers State Bank, Valparaiso  
Davis, Carl M.

301 Indiana Ave., Valparaiso

DeGrazia, Eugene  
810 LaPorte Ave., Valparaiso  
DeWitt, Charles E. (S)  
23 Lincoln Way, Valparaiso  
Dittmer, Thomas L. (S)  
23 Lincoln Way, Valparaiso  
Douglas, Geo. R. (S)  
23 Lincoln Way, Valparaiso  
Eades, Ralph C.  
501 Lincoln Way, Valparaiso  
Frank, John R.  
23 Lincoln Way, Valparaiso  
LaRocca, Joseph,  
402 Erie, Valparaiso  
Makovsky, Theodore  
808 Lincoln Way, Valparaiso  
Miller, Ebbo H.  
608 Union St., Valparaiso  
Nash, Charles B.  
23 Lincoln Way, Valparaiso  
Powell, Edgar H.  
23 Lincoln Way, Valparaiso  
VanWinkle, Arthur J. . .Valparaiso  
Vietzke, Paul C. F.  
60 Jefferson, Valparaiso  
Gordon, Joseph L. . . . .Wheeler  
Adair, Fred L. (H)  
P.O. Box 158, Maitland, Fla.

**POSEY COUNTY**

Montgomery, Samuel B. (S)  
Cynthia  
Ropp, Harold E. . . . .New Harmony  
Thompson, Lewis R. . .New Harmony  
Boren, Paul . . . . .Poseyville  
Boren, Samuel W. (S) . . .Poseyville  
Woods, Arba L. . . . .Poseyville  
Challman, William B. . .Mt. Vernon  
Herr, John W. . . . .Mt. Vernon  
Oliphant, Frank W. . . .Mt. Vernon  
Vogel, L. John . . . . .Mt. Vernon  
Williams, Frederic . . . .Mt. Vernon

**PULASKI COUNTY**

Dublin, Madeline . . . .Francesville  
Ives, Raymond J. . . . .Francesville  
Gillespie, Chauncey . .Medaryville  
Linton, Charles E. (S) . .Medaryville  
Carneal, Thomas E. . . .Winamac  
Halleck, Harold J. . . . .Winamac  
Thompson, William R. . .Winamac  
Yale, Charles A. . . . .Winamac

**PUTNAM COUNTY**

Veach, Lester W. . . . .Bainbridge  
Veach, Richard L. . . . .Bainbridge  
Gray, Clyde C. . . . .Cloverdale  
Huckleberry, Carl D. . . .Cloverdale  
Dettloff, Frederick . . .Greencastle  
Dobbs, O. R. . . . .Greencastle  
Fuson, Wenfred J. . . .Greencastle  
Gillespie, Joseph F. (S)

Greencastle  
Johnson, James B. . . . .Greencastle  
Nichols, Anne Sackett .Greencastle  
Parker, George F. . . . .Greencastle  
Rhea, Gilbert D. . . . .Greencastle  
Schauwecker, Cleon M. .Greencastle  
Steele, Dick J. . . . .Greencastle  
Tennis, George T. . . . .Greencastle  
Tipton, William R. . . . .Greencastle  
Wiseman, V. Earle . . . .Greencastle  
Gwaltney, Loral F. . . . .Roachdale  
Richards, Edgar E. . . .Russellville



**RANDOLPH COUNTY**

Nixon, Byron ..... Farmland  
 White, Harvey E. .... Farmland  
 Harmon, Wayne ..... Lynn  
 Jordan, Leo E. .... Lynn  
 Martin, Charles E. .... Lynn  
 Slick, Crystal R. .... Lynn  
 Shallenberger, Henry R. .... Modoc  
 Hinchman, Jean ..... Parker  
 Henderson, Arvin ..... Ridgeville  
 Potter, Richard M. .... Ridgeville  
 Chambers, Leroy B. .... Union City  
 Gullett, Charles C. .... Union City  
 Phipps, Leland K. .... Union City  
 Reid, Robert W. .... Union City  
 Ruby, Fred M. .... Union City  
 Voisinot, Raymond A. .... Union City  
 Wills, Benjamin F. .... Union City  
 Brenner, Ivan E. .... Winchester  
 DeRyke, Gilbert R. .... Winchester  
 Dininger, William S. .... Winchester  
 Engle, Russell B. .... Winchester  
 Painter, Lowell W. .... Winchester  
 Robison, John S. .... Winchester  
 Sparks, Paul W. .... Winchester

**RIPLEY COUNTY**

Hisrich, Lloyd W. .... Batesville  
 Lippoldt, Charles L. .... Batesville  
 Obery, George A. .... Batesville  
 Conrad, Henry W. .... Milan  
 Hunter, Lowell G. .... Milan  
 Warn, William J. .... Milan  
 Row, George S. .... Osgood  
 Smith, R. Lee ..... Osgood  
 McConnell, William C. .... Sunman  
 Fletcher, Charles F. .... Sunman  
 Hopkins, Lester H. .... Versailles  
 Moran, Noel D. .... Versailles

**RUSH COUNTY**

McNabb, George B. .... Carthage  
 Worth, C. Willard ..... Milroy

**Rushville**

Atkins, C. C. .... 225 N. Morgan  
 Corpe, Kenneth F. .... Rushville  
 Dean, Donald I. .... 310 E. Fifth  
 Denny, Melvin H. .... 127 W. Third  
 Ellis, Davis W. .... 4th and Main Sts.  
 Green, Frank, Jr. .... 134 E. Second  
 Johnson, Robt. B. .... 229 N. Morgan  
 Kennedy, Robt. O. .... 118 W. Third  
 Nutter, W. H. .... 205 W. Third  
 Shanks, Roy E. .... I.O.O.F. Bldg.  
 Truman, Elmer M. .... 733 N. Morgan

**ST. JOSEPH COUNTY**

Houser, D. Stanley ..... Lakeville  
 How, John T. (S) ..... Lakeville

**Mishawaka**

Barone, C. V. .... 312 Lincolnway W.  
 Bassler, C. R. .... Mishawaka Tr. Bldg.  
 Christophel, Verna .... 109 W. Third  
 Ganser, Richard A. ....  
     114 Lincolnway W.  
 Goethals, C. J. .... 602 Lincolnway W.  
 Joest, Charles O. .... 113 S. Church  
 Logan, Francis W. ....  
     208 First Nat. Bk. Bldg.  
 Martin, Charles F. .... 224 S. Mill St.  
 Orr, Robert ..... 124 S. Race  
 Rosenwasser, Jacob .....  
     228 Lincolnway East

Sirlin, Edw. M. .... 111 S. Church  
 Spalding, Wendell L. ....  
     212 First Nat. Bk. Bldg.  
 Templeton, A. R. .... 522 Calhoun St.  
 Van Rie, Leo P. .... 116 S. West  
 Walerko, Frank ..... 204 Polis Bldg.  
 Walters, Charles ..... 206 Polis Bldg.  
 Ward, Jas. W. .... 316 Lincolnway W.  
 Whitlock, Francis ..... 110 N. Race St.  
 Whitlock, Merle E. .... 123 W. Fourth  
 Wixted, Jno. F. .... 114 Lincolnway W.  
 Wixted, Julia F. ....  
     114 Lincolnway, W.

Wurster, Herbert C. .... 221 E. Third  
 Wygant, Marion D. .... 116 W. Third  
 Wyland, Byron J. .... 116 W. Third  
 Zimmer, H. J. .... 119½ Lincolnway W.

Luzadder, John E., Jr. .... New Carlisle  
 Hardy, John J. .... North Liberty  
 Warrick, Homer Lyle ..... Osceola

**South Bend****A**

Abel, Joseph A. .... 1222 Western Ave.  
 Acker, Robert B. ....

    418 Sherland Bldg.  
 Arisman, Ralph K. ....  
     711 Odd Fellow Bldg.

**B**

Balla, Morris ..... 404 Sherland Bldg.  
 Baran, Charles ..... 710 J.M.S. Bldg.  
 Bartsch, Harvey L. ....  
     502 J.M.S. Bldg.

Bechtold, Samuel E. ....  
     730 Sherland Bldg.  
 Bennett, Jene R. .... 531 Main St.  
 Berke, Robert D. ....  
     102 E. Colfax Ave.

Biasini, Benedict A. ....  
     401 Dixie Way North

Bickel, David A. ....  
     515 Odd Fellows Bldg.

Birmingham, Peter J. ....  
     426 Sherland Bldg.

Bishop, Charles A. ....  
     122 N. Lafayette Blvd.

Bixler, Louis C. .... 615 Sherland Bldg.  
 Blackburn, Erwin .....  
     508 Sherland Bldg.

Bodnar, Leslie M. ....  
     215 Poledor Bldg.

Bolka, Bernard ..... 728 W. Colfax  
 Borough, L. D. .... 710 J.M.S. Bldg.  
 Bosenbury, Charles S. (S) .....  
     323 W. Navarre St.

Brechtel, Harvey J. ....  
     1016 W. Washington St.

Bryan, Robert J. ....  
     1002 Lincolnway W.

Buchanan, Wallace D. ....  
     825 Sherland Bldg.

Buechner, Frederick W. ....  
     116 N. Main St.

Bussard, Clifford F. ....  
     634 Associates Bldg.

Bussard, Frank .....  
     634 Associates Bldg.

**C**

Carter, F. R. N. .... 605 Sherland Bldg.  
 Cassady, James V. ....  
     921 Lincoln Way East

Clark, Stanley A. (S) .....  
     1242 E. Jefferson St.

Clark, William H. ....  
     122 N. Lafayette Blvd.

Colip, George D. ....  
     514 Sherland Bldg.

Condit, David H. ....  
     122 N. Lafayette Blvd.

Cook, Gordon C. ....  
     122 N. Lafayette Blvd.

Cooper, Harry L. ....  
     410 Sherland Bldg.

Culbertson, Carl S. .... 531 N. Main St.  
 Custer, Edward W. ....  
     Healthwin Sanitarium

**D**

Denham, Robert H. ....  
     425 Odd Fellows Bldg.

Dietl, Ernest L. .... 822 Sherland Bldg.  
 Dodd, Robert D. .... 759 Portage Ave.  
 Dolezal, Bernard J. ....  
     530 N. Main St.

Donnelly, Everett F. ....  
     530 W. Indiana Ave.

Duggan, James A. ....  
     316 St. Joseph Bank Bldg.

Dunlap, D. Logan ..... 716 J.M.S. Bldg.

**E**

Edwards, Bernard E. ....  
     226 Sherland Bldg.

Egan, Sherman ..... 301 Sherland Bldg.  
 Ellison, Alfred ..... 826 Sherland Bldg.

English, John P. ....  
     122 N. Lafayette Blvd.

Ericksen, Lester G. ....  
     615 Sherland Bldg.

Erickson, Gustaf W. ....  
     122 N. Lafayette Blvd.

**F**

Faltin, Ladislaus .....  
     609 Odd Fellows Bldg.

Feldman, Max ..... 1921 Miami St.  
 Filipek, Walter J. ....  
     311 Odd Fellows Bldg.

Firestein, Ben Z. .... 703 J.M.S. Bldg.  
 Fish, Clyde M. .... 723 Sherland Bldg.

Fish, Edson C. ....  
     401 N. Notre Dame Ave.

Fisher, Lawrence F. ....  
     825 Sherland Bldg.

Frank, Lyall L. .... 534 N. Lafayette  
 Frash, DeVon W. .... 306 J.M.S. Bldg.

Frey William B. .... 209 Poledor Bldg.  
 Friedman, Morris S. ....  
     218 Poledor Bldg.

Frith, Gladys .....  
     521 W. Washington Ave.

Frith, Louis G. ....  
     521 W. Washington Ave.

**G**

Gates, George E. ....  
     122 N. Lafayette Blvd.

Gilman, Marcus M. ....  
     403 Odd Fellow Bldg.

Giordano, Alfred S. ....  
     531 N. Main St.

Godersky, George E. ....  
     512 Odd Fellows Bldg.

Gordon, J. M. (S) .... 726 J.M.S. Bldg.  
 Green, G. F. .... 822 Sherland Bldg.

Green, Norval E. .... 704 N. Main St.  
 Grillo, Donald ..... 530 Sherland Bldg.

Grorud, Alton C. ....  
     120 Lafayette Blvd.



## ST. JOSEPH COUNTY

### (South Bend—Continued)

## H

Haley, Paul E. . . . 401 Sherland Bldg.  
Hall, James M. . . . 230 Sherland Bldg.  
Hamilton, Chas. D. . . . 1498 Northern Ave.  
Harmon, V. E. . . . 302 Sherland Bldg.  
Haugseth, Ellsworth K. . . . 122 Lafayette Blvd.  
Helmen, H. W. . . . 120 Franklin Place  
Helmer, John F. . . . 826 Sherland Bldg.  
Hewitt, M. I. . . . 315 Sherland Bldg.  
Hilbert, J. W. . . . 410 W. Washington  
Hillman, M. W. . . . 429 Sherland Bldg.  
Hillman, W. H. (S) . . . 429 Sherland Bldg.  
Hoffman, R. V. . . . 416 Sherland Bldg.  
Holdeman, L. S. . . . 404 N. Lafayette  
Holdeman, R. W. . . . 404 N. Lafayette  
How, Louis E. . . . 6107 S. Michigan  
Hyde, C. C. . . . 122 N. Lafayette  
Johns, N. C. . . . 718 Sherland Bldg.

## K

Kamm, B. A. . . . 526 Sherland Bldg.  
Karn, John . . . 728 W. Colfax Ave.  
Knapp, Arthur L. . . . 2215 Mishawaka  
Knode, K. T. . . . 729 Sherland Bldg.  
Kramer, Albert A. . . . 1519 Miami  
Krueger, John E. . . . 401 N. Notre Dame Ave.  
Kuhn, F. L. . . . 1215 S. Michigan

## L

Lane, William H. . . . 604 N. Main  
Lang, Joseph E. . . . 730 J.M.S. Bldg.  
Langenbahn, Carl J. . . . 206 Sherland Bldg.  
Lionberger, John R. . . . 615 Sherland Bldg.  
Liss, E. C. . . . 317 Odd Fellow Bldg.  
Lockhart, Philip B. . . . 825 Sherland Bldg.  
Ludwick, H. . . . 2730 Lincolnway W.  
Luginbill, Howard M. . . . 3201 Mishawaka Ave.  
Luthy, Karl R. . . . 1204 E. Bronson St.

## M

Mason, Bernard A. . . . 122 N. Lafayette Blvd.  
McCraley, W. J. . . . 406 Sherland Bldg.  
McDonald, R. M. . . . 410 J.M.S. Bldg.  
McFarland, Corley B. . . . 122 N. Lafayette Blvd.  
McKenna, H. J. . . . 1615 E. Wayne  
Metcalf, Grant E. . . . 319 Odd Fellow Bldg.  
Mikesch, W. H. . . . 816 Sherland Bldg.  
Miller, Milo K. . . . 122 N. Lafayette Blvd.  
Mott, C. A. . . . 1801½ W. Washington  
Mueller, Hilbert M. . . . 122 N. Lafayette Blvd.  
Murphy, Eugene C. . . . 122 N. Lafayette Blvd.  
Murphy, J. F. . . . 625 J.M.S. Bldg.

## N-O

Nelson, F. Dale . . . 428 Sherland Bldg.  
Nelson, R. E. . . . 510 Sherland Bldg.  
Olney, T. A. (S) . . . Country Club Rd.  
Olson, K. L. . . . 615 Sherland Bldg.

## P

Parke, D. Davis . . . St. Joseph Hosp.  
Pauszek, T. B. . . . 726 W. Washington  
Petrass, A. . . . 516 Sherland Bldg.  
Plain, George . . . 122 N. Lafayette Blvd.  
Potter, Thomas P. Jr. . . . 531 N. Main St.  
Proudfit, Charles H. . . . 525 Odd Fellow Bldg.  
Pyle, H. D. . . . 518 Sherland Bldg.

## R

Rasmussen, Ruth F. . . . 122 N. Lafayette Blvd.  
Rigley, E. L. . . . 408 Sherland Bldg.  
Rodin, H. H. . . . 422 Sherland Bldg.  
Rosenheimer, G. M. . . . 604 N. Main  
Rubens, Eli . . . 408 Odd Fellows Bldg.  
Rudolph, Carl J. . . . 617 J.M.S. Bldg.

## S

Sanderson, Robert B. . . . 730 Sherland Bldg.  
Sandock, I. . . . 402 Sherland Bldg.  
Sandock, Louis F. . . . 406 Platt Bldg.  
Sandoz, Harry H. . . . 615 Odd Fellow Bldg.  
Savery, C. E. . . . 230 Sherland Bldg.  
Schiller, H. A. . . . 510 Sherland Bldg.  
Scott, F. M. . . . 122 N. Lafayette Blvd.  
Selby, Keith E. . . . 407 Lincolnway W.  
Sellers, Francis M. . . . 1602 E. Wayne  
Sennett, C. M. . . . 318 Sherland Bldg.  
Sensenich, R. L. . . . 203 J.M.S. Bldg.  
Sharp, Merle C. . . . 120 N. Lafayette Blvd.  
Shelley, Edw. . . . 728 W. Colfax  
Shively, John A. . . . 531 N. Main St.  
Skillern, P. G. . . . 1002 Bldg. & Ln. Tr.  
Slominski, Harry H. . . . 708 Odd Fellow Bldg.  
Spenner, R. W. . . . 726 Sherland Bldg.  
Staunton, H. A. . . . 3023½ Mishawaka  
Stiver, D. D. . . . 822 Sherland Bldg.  
Stratigos, Joseph S. . . . 713 E. Jefferson Blvd.

## T

Thompson, John M. . . . 921 Lincoln Way East  
Thompson, Robert A. . . . 530 W. Indiana Ave.  
Thornton, M. J. . . . 825 Sherland Bldg.  
Traver, P. C. . . . 1010 Riverside Dr.

## V-W

Vagner, S. Bernard . . . 1303½ W. Washington  
Vurpillat, Francis J. . . . 132 N. Lafayette Blvd.  
Wegner, W. G. (S) . . . 616 W. Wash.  
Weiss, Eugene . . . 2521 S. Michigan  
Wilhelm, A. M. . . . 628 Sherland Bldg.  
Wilson, James . . . 409 J.M.S. Bldg.  
Zeiger, Irvin . . . 3201 Mishawaka

Nassef, George J. . . . Walkerton  
Cline, Kenneth L. . . . Wyatt  
Chambers, William . . . 706 Carew Tower, Cincinnati, O.

Cunningham, Robert D. . . . Gen. Hosp., Charleston, W. Va.  
Firestein, Ray . . . Cook Co. Hospital, Chicago, Ill.  
Rowdabaugh, Marshall J. . . . 1413 N. 17th Ave., Melrose Park, Ill.

## SCOTT COUNTY

Bogardus, Carl R. . . . Austin  
Hill, Thomas N. . . . Scottsburg  
McClain, Marvin L. . . . Scottsburg  
Napper, Floyd S. . . . Scottsburg

## SHELBY COUNTY

Nigh, Rufus M. . . . Fairland  
Davis, John A. . . . Flat Rock  
Nave, H. E. . . . Fountaintown  
Miller, Frank H. . . . Morristown  
Patten, Vernon C. (S) . . . Morristown

## Shelbyville

Barnum, Emerson . . . Methodist Bldg.  
Billman, Gustus S. . . . R. R. 2  
Dalton, Wilson L. . . . Methodist Bldg.  
Gehres, Robert W. . . . 15 S. Tompkins  
Inlow, H. H. . . . 103 W. Washington  
Inlow, W. D. . . . 103 W. Washington  
Miller, Richard C. . . . 17 Mechanic  
Richard, N. F. . . . 103 W. Washington  
Scott, V. B. . . . 103 W. Washington  
Silbert, David B. . . . Pitman Bldg.  
Spindler, Robt. D. . . . 165 W. Mechanic  
Tindall, Paul R. . . . 20 N. Pike  
Tindall, W. R. . . . 505 S. Harrison  
Whitcomb, Roger F. . . . 302 Methodist Bldg.

Coulson, Sewell B. . . . Waldron  
Keeling, James E. (S) . . . Waldron  
Fodor, Oscar . . . 5306 E. 180th St., Seattle 55, Wash.

## SPENCER COUNTY

Barrow, John H. . . . Dale  
Medcalf, Norman L. . . . Lamar  
Jolly, Wesley P. . . . Richland  
Atchison, Kenneth C. . . . Rockport  
Ehrman, C. D. . . . Rockport  
Glackman, John C., Jr. . . . Rockport  
Kerrigan, William F. . . . Rockport

## STARKE COUNTY

DeNaut, James F. . . . Knox  
Henry, Howard S. . . . Knox  
Ingwell, Guy B. . . . Knox  
McClure, Clark . . . Knox  
Farabee, Charles R. . . . North Judson  
Matthew, J. R. . . . North Judson

## STEUBEN COUNTY

Barton, Robert . . . Angola  
Creel, Donald W. . . . Angola  
Crum, Marion M. . . . Angola  
Hartman, John J. . . . Angola  
Kissinger, Knight L. . . . Angola  
Lane, William H. (S) . . . Angola  
Mason, Donald G. . . . Angola  
Rausch, Norman W. . . . Angola  
Waller, William F. . . . Angola  
Blosser, Blaine A. . . . Fremont  
Hippensteele, Ralph O. . . . Fremont  
Alford, James . . . Hamilton  
Denman, Robert D. (S) . . . Helmer



**SULLIVAN COUNTY**

Brown, John S. .... Carlisle  
Whipps, Charles E. .... Carlisle  
Dukes, Betty ..... Dugger  
Dukes, Frederic M. .... Dugger  
Dukes, Joe E. .... Dugger  
Bland, Herbert E. (S) ... Fairbanks  
Bethea, Robert O. .... Farmersburg  
O'Dell, Harry C. .... Farmersburg  
Oliphant, Jacob T. .... Farmersburg  
Hamilton, Antha Ann. .... Shelburn  
Bedwell, Marion H. .... Sullivan  
Briggs, Carl F. .... Sullivan  
Crowder, James H., Jr. .... Sullivan  
Maple, James B. .... Sullivan  
Scott, Garland D. .... Sullivan  
Scott, Irvin H. .... Sullivan

**SWITZERLAND COUNTY**

(See Jefferson-Switzerland)

**TIPPECANOE COUNTY**

Wagoner, Robert H. (S) ... Colburn

**Lafayette**

Ade, C. H. .... 2211 South St.  
Ade, Mary K. .... 2211 South St.  
Arnett, Arett C. .... 312 N. Eighth  
Balkema, C. M. ....  
623 Lafayette Life Bldg.  
Bauer, Arthur J. .... 112 N. Seventh  
Bayley, William E. .... Home Hospital  
Beeler, James M. ....  
Wabash Valley Sanitarium  
Buhrmester, Harry C., Jr. ....  
312 N. Eighth  
Burkle, John C. .... 133 N. Fourth  
Calvert, Raymond R. .... 314 N. Sixth  
Cole, Ira ..... 2315 South  
Cox, Wayne T. .... 206-7 Schultz Bldg.  
Coyner, Alfred B. ....  
509 Lafayette Life Bldg.  
Crockett, Franklin S. ....  
312 Lafayette Life Bldg.  
Dewey, G. W. (S) .... 122 S. 28th St.  
Donahue, George R. ....  
718 Lafayette Life Bldg.  
Dubois, Ramon B. .... 2211 South St.  
Eaton, M. J. .... Lafayette Life Bldg.  
Engeler, James E. .... 308 N. Eighth  
Ferguson, Wm. B. .... 2211 South St.  
Flack, Russell A. .... 217 N. Sixth  
Frasch, M. G. .... Lafayette Life Bldg.  
Frey, Harley B. ....  
405 Lafayette Life Bldg.  
Gery, Richard E. .... 312 N. Eighth  
Gripe, R. P. .... 312 N. 8th St.  
Harden, Murray ....  
716 Lafayette Life Bldg.  
Harshman, M. L. .... 312 N. Eighth  
Harter, Eli Blair .... 312 N. Eighth  
Herrold, George W. ....  
2323 South St.  
Holladay, Lloyd J. ....  
411 Lafayette Life Bldg.  
Hughes, Richard .... 2216 South St.  
Hunsberger, W. G. .... 506 S. 7th St.  
Hunter, F. P. .... Lafayette Life Bldg.  
Ikens, Ray G. .... 605 S. Seventh  
Johnson, Herbert S. .... 312 N. 8th St.  
Johnson, Lowell R. .... 2315 South  
Jones, David .... 24 N. Twenty-fourth  
Karberg, R. J. .... 420 Columbia St.  
Klatch, Ben Z. .... 2211 South St.

Klepinger, Harry E. ....  
824 Lafayette Life Bldg.  
Laws, H. J. ....  
501 Lafayette Life Bldg.  
Laws, Kenneth F. ....  
501 Lafayette Life Bldg.  
Levering, Guy P. (S) ....  
819 Central St.  
Loop, Floyd A. (S) ....  
Lafayette Life Bldg.  
Loop, F. A. .... Lafayette Life Bldg.  
McAdams, H. B. .... 631 Columbia St.  
McClelland, D. C. .... 312 N. Eighth  
McFadden, James M. ....  
St. Elizabeth Hosp.  
McKinley, Joseph ....  
312 Lafayette Life Bldg.  
McKinney, Daniel H. ....  
814 Lafayette Life Bldg.  
Marsh, G. W. .... 1405 N. Fourteenth  
Miller, Roland E. .... 1625 Kossuth  
Morrison, John S. (S) ....  
Lafayette Life Bldg.  
Neumann, Kenneth O. ....  
613 Lafayette Life Bldg.  
Pearlman, Samuel S. .... 107 N. Sixth  
Peterson, Joel A. ....  
609 Lafayette Life Bldg.  
Peyton, Frank W. .... 15 N. 25th  
Ratcliff, Frank W. .... 300 Main  
Rothrock, Philip W. .... 1625 Kossuth  
Ruschli, Edward B. ....  
510 Lafayette Life Bldg.  
Shafer, John W. (S) .... 619 Kossuth  
Sholty, William M. ....  
405 Lafayette Life Bldg.  
Smith, Lowell C. .... 405 Schultz Bldg.  
Stahl, Edward T. .... 312 N. Eighth  
Strayer, Joseph W. ....  
612 Lafayette Life Bldg.  
Strickland, Martha B. ....  
2211 South St.  
Thomas, Gordon A. .... 608 Columbia  
Trout, Carl J. .... 314 N. Sixth  
Tubbs, George R. (S) ....  
608 Columbia  
VanBuskirk, E. L. .... 308 N. Eighth  
Vermilya, Robert W. ....  
405 Lafayette Life Bldg.  
Washburn, Will W. .... 312 N. Eighth  
Mitchell, Edgar T. .... Romney  
Babb, Forrest J. .... Stockwell

**West Lafayette**

Ash, Harold H. .... 200 South St.  
Carroll, Bertha Rose ....  
Purdue University  
Mather, Robert L. .... 254 Littleton  
Meikle, Louise J. .... 606 Ferry Lane  
Miller, Sayers J. .... Purdue Univ.  
Romberger, Floyd T. .... 424 Littleton  
Rommel, C. H. .... 460 Northwestern  
Spurlock, Fae H. .... 214 Northwestern  
Stapleton, Pauline ....  
1520 Summit Drive  
Taylor, Eugene E. .... Purdue Univ.  
Greist, Oliver E. ....  
1722 N.E. 8th St., Ft. Lauderdale,  
Fla.

**TIPTON COUNTY**

Cotton, Stanley M. .... Goldsmith  
Dunham, Wilbur F. .... Kempton  
Stouder, Albert E. .... Kempton  
Tranter, William F. .... Sharpsville

Burkhardt, Boyd A. .... Tipton  
Carter, Jean V. .... Tipton  
Compton, George .... Tipton  
Gossard, Meredith B. .... Tipton  
Kurtz, William A. .... Tipton  
Warne, George H. .... Tipton  
Ericson, Harold L. .... Windfall  
Moser, Elmer B. .... Windfall

**UNION COUNTY**

(See Wayne-Union)

**VANDERBURGH COUNTY****Evansville****A**

Acre, Robert R. .... 617 Hulman Bldg.  
Adler, Raymond N. .... 714 Second  
Alexander, John E. ....  
609 Hulman Bldg.  
Anderson, Dwight W. .... 814 N. Main  
Antes, Earl H. .... 412 SE Fourth  
Austin, E. W. .... 216 SE Riverside Dr.

**B**

Baker, H. M. .... 402 Hulman Bldg.  
Baker, Jas. S. (S) ....  
407 Metro Bank Bldg.  
Baker, Mason R. .... 957 S. Ky. Ave.  
Ballas, William A. ....

**Deaconess Hospital**

Barclay, Irvin C. .... 114 SE Second  
Barnhart, Willard T. .... 527 Sycamore  
Baylor, Edward M. .... 415 S. Lincoln  
Beck, Robert E. .... 600 Mary St.  
Begley, Joseph W. Jr. ....

**314 S.E. Riverside Drive**

Bennett, Abner ....  
Welborn Baptist Hospital  
Bissonnette, Roger P. ....

**412 S.E. 4th St.**

Boswell, R. W. C. .... 2509 Wash.  
Boyd, Stella N. .... 502 Hulman Bldg.  
Brockmole, A. W. .... 700 Mary St.  
Brown, J. A., Jr. .... 605 E. Sixth  
Bryan, S. L. .... 607 Hulman Bldg.  
Buchholz, R. R. .... 412 SE Fourth  
Buehner, Donald F. ....

**2104 Washington Ave.**

Buikstra, C. R. .... 609 Hulman Bldg.

**C**

Cacia, John J. .... 609 Hulman Bldg.  
Caldwell, W. C. .... 504 Old Nat. Bk.  
Clements, Albert F. .... 15 SE Second  
Clouse, Paul A. ....

**613 S. Weinbach Ave.**

Cockrum, W. M. .... 908 Hulman Bldg.  
Cody, Burtis L. .... 204 Boehne Bldg.  
Coleman, Joseph E. ....

**216 SE Riverside Dr.**

Combs, H. T. .... 807 W. Indiana  
Combs, Jno. H. .... 412 SE Fourth  
Combs, Pearl B. .... 1623 Lincoln  
Corcoran, P. J. V. .... 118 S. First  
Crawford, Jas. H. .... 221 Chestnut  
Crevello, Albert J. ....

**Clearview Hosp., Kratzville Rd.**

Crimm, Paul D. .... Boehne Hosp.  
Cullnane, C. W. .... 2312 W. Franklin

**D**

Daves, William L. ....  
608 Old Nat. Bk. Bldg.  
Deems, Myers B. ....  
314 SE Riverside Dr.



## VANDERBURGH COUNTY

(Evansville—Continued)

Denzer, Edw. K....108 SE Second  
 Denzer, Wm. O....108 SE Second  
 Dieckman, H. S. 1012 Cit. Bk. Bldg.  
 Diefendorf, Charles F. (S)  
 2106B W. Franklin  
 Durkee, Melvin S.  
 403 Citizens Nat. Bk. Bldg.  
 Dycus, Walter A.  
 319 N. St. Joseph Ave.  
 Dyer, W. K....221 Chestnut St.

## E

Ehrich, William S.  
 808 Old Nat. Bk. Bldg.  
 Eisterhold, J. A. 314 SE Riverside  
 Engel, Edgar L...126 SE Seventh

## F

Faul, Henry J...815 Hulman Bldg  
 Fenneman, Robert J.  
 609 Hulman Bldg.  
 Fickas, Dallas .....619 Mary St.  
 Fisher, Wm. C....413 First Ave.  
 Fitz Gerald, Maurice D.  
 St. Mary's Hospital  
 Fitzsimmons, E. L...527 Sycamore  
 Flinn, J. H....221 Chestnut St.  
 French, Wm. G....Sta. D, Box 2006  
 Fritsch, Louis E.....1201 First

## G

Garland, Edgar A. 606 S. Weinbach  
 Gaul, L. Edw....509 Hulman Bldg.  
 Gill, Bernard P....113½ NW Fifth  
 Grant, John H....957 S. Kentucky  
 Griep, Arthur H....412 SE Fourth

## H

Hammond, R. Case  
 527 Sycamore St.  
 Hare, Daniel M. 617 Hulman Bldg.  
 Hare, John H. Evansville St. Hosp.  
 Harris, Wm. Lee....115 SE 6th St.  
 Hartley, C. A., Jr....221 Chestnut  
 Hartz, F. Minton....123 SE Second  
 Heard, Albert .....322 E. Cherry  
 Hefti, Karl R.....125 SE Second  
 Heinrich, Weston A.  
 314 S.E. Riverside Drive  
 Herrman, Gordon T.  
 402 Hulman Bldg.  
 Herzer, Clarence C...322 N. Fulton  
 Hobbs, Arthur .....600 Mary St.  
 Hoopes, Jane M....125 SE Second  
 Huggins, Victor S.  
 601 Citizens Nat. Bk. Bldg.  
 Hyatt, Gilbert T....412 SE Fourth

## J

Johnson, G. C. (S)  
 212 Indiana Bank Bldg.  
 Johnson, Stephen L...521 Sycamore

## K

Kauffman, Harley M. 219 Walnut  
 Kessler, Robt. B...1338 Division St.  
 Kiechle, F. L....Boehne Hosp.  
 Kleindorfer, R. L. 819 W. Franklin

## L

Lang, Shirley C...957 S. Kentucky  
 Laubscher, Clarence Kratzville Rd.

Lawrence, Jos. C....413 First Ave.  
 Leigh, Chas. F....124 SE First  
 Leslie, Ermil T....122 Locust  
 Logan, Jesse R....503 First Ave.  
 Lynch, Harold D. 216 SE Riverside  
 Lynch, Paul V.  
 Evansville State Hosp.

## M

McCool, Joe H...314 SE Riverside  
 McCool, William E. (S)  
 R. R. 5, Camp Ground Rd.  
 Macer, C. G....901 Hulman Bldg.  
 MacKenzie, Pierce 126 SE Seventh  
 Mason, E. E....906 Hulman Bldg.  
 Mehl, Rudolph A....752 S. Eighth  
 Meyer, Keith T....118 SE First  
 Miller, Laverne B....714 N. Main  
 Miller, Milton .....103 N. Main  
 Miller, Minor....Court Hse. Annex  
 Miller, Robert J....1905 Division  
 Mills, Fred E....Deaconess Hosp.  
 Mino, Raymond W...723 Mary St.  
 Mino, Victor H....723 Mary  
 Moehlenkamp, Charles E.  
 614 N. Governor  
 Muelchi, A. F...518 Hulman Bldg.  
 Murphy, Edw. U.  
 908 Hulman Bldg.

## N

Nenneker, Henry (S)  
 Harmonyway  
 Neucks, H. C...207 SE First St.  
 Newman, A. E...912 Hulman Bldg.  
 Niedermayer, Alfred J.  
 960 Washington Ave.  
 Nisenbaum, Harold  
 704 Hulman Bldg.  
 Nonte, Leo R. 1651-B Lincoln Ave.

## O

Oppenheimer, Ernst 103 SE Second  
 Oswald, Robert  
 840 Bayard Park Dr.

## P

Pastor, Julius W...713 First Ave.  
 Pollard, Walter S. 115 SE Second  
 Porro, Francis W. St. Marys Hosp.  
 Present, Julian...113 S.E. Second  
 Price, Shirley G...420 Cherry St.  
 Pugh, Willis .....413 First

## R

Raphael, I. J...617 Hulman Bldg.  
 Ratcliffe, A. W....510 SE First  
 Ravdin, B. D....712 Hulman Bldg.  
 Reich, Clarence E...1209 N. Fulton  
 Reitz, Thos. F....700 N. Sixth  
 Ringham, Jarrett  
 401 Chandler Ave.  
 Rininger, H. C...1359 Washington  
 Ritchie, William D.  
 608 Old Nat'l Bank Bldg.  
 Ritz, Albert S....2605 Lincoln  
 Robinson, Earle U. 615 Bellemeade  
 Rosenblatt, B. B. 709 Hulman Bldg.  
 Rossow, Russell...118 SE First  
 Royster, G. M....810 Cit. Bk. Bldg.  
 Royster, R. A....810 Cit. Bk. Bldg.  
 Ruddick, H. C...816 Hulman Bldg.  
 Rusche, Henry J....313 W. Iowa  
 Russell, Richard H.  
 St. Mary's Hospital

## S

Schaefer, William C.  
 St. Mary's Hospital  
 Schirmer, R. H...1118 W. Franklin  
 Schneider, Charles P.  
 2211 W. Franklin St.  
 Schriefer, Victor V.  
 420 N. Main St.  
 Slaughter, H. C. 908 Hulman Bldg.  
 Slaughter, John 808 Cit. Bk. Bldg.  
 Slaughter, O. L....118 E. First  
 Snively, W. D., Jr.  
 Mead Johnson & Co.  
 Springstun, Walter R.  
 601 Hulman Bldg.  
 Steele, Paul W.  
 1651-B Lincoln Ave.  
 Sterne, John ....308 Wright Bldg.  
 Strueh, Paul E....124 S. First St.  
 Stork, Urban.....412 SE Fourth  
 Sutter, Chas. C.  
 Evansville State Hosp.

## T

Tager, Stephen...219 Walnut St.  
 Taylor, Eugene C....853 Lincoln  
 Tilden, Margaret 200 S. Parker Dr.  
 Tweedall, D. C....527 Sycamore St.  
 Tweedall, D. G...2114 W. Franklin

## U-V

Underwood, Gordon B.  
 509 Hulman Bldg.  
 Viehe, Robt. W....207 SE First  
 Visher, John W.  
 805 Old Nat. Bk. Bldg.

## W

Watson, James L.  
 1158 Lincoln Ave.  
 Weber, Edgar H...123 SE Second  
 Weiss, Henry G. (S)  
 614 Hulman Bldg.  
 Welborn, Mell B...412 SE Fourth  
 Wesson, Thos. W....124 SE First  
 Wilhelmus, C. Kenneth  
 115 SE 7th St.  
 Wilhelmus, Gilbert....1028 Wash.  
 Wilhelmus, Wm. M....R. R. 7  
 Willis, Chas. F....1100 S. Bedford  
 Willison, G. W....118 SE First  
 Wilson, J. D....517 Sycamore St.  
 Wilson, Ralph .....517 Mary  
 Wishart, Shelby W.  
 416 3rd & Main Bldg.  
 Woods, Wm. P. (S) 15 SE Seventh  
 Wynn, J. F....906 Hulman Bldg.

## X-Y-Z

Yeck, Charles W....115 SE Sixth  
 Young, C. Curtis 126 SE Seventh  
 Zimmerman, Harold .6 SE Second  
 Brown, Robert L.  
 Camp Carson, Colo.  
 Burnikel, Ray H.  
 Gen. Hosp., Milwaukee, Wisc.  
 Dodd, Roberts K.  
 5749 Pine St., Philadelphia, Pa.  
 Clinton, Okla.  
 Hart, L. Paul...1454 Coolidge Dr.,  
 University City, Mo.  
 King, Everett A.  
 14th C.G. District, Pier 4,  
 Honolulu, H. T.  
 Kirch, Leo  
 Norton Gen. Hosp., Norton, Va.

## VANDERBURGH COUNTY

(Continued)

McDonald, Jos. D. . . . 1463 Coolidge,  
University City, Mo.  
Visher, John S.  
1554 Campus Dr., Berkley, Calif.  
Wyatt, Fred H. . . . 1301 Garfield St.,  
Denver, Colo.

## VERMILLION COUNTY

(See Parke-Vermillion)

## VIGO COUNTY

Loving, Jury B. . . . . New Goshen  
DuPuy, Charles M. (S) . . . . . Riley  
McIntosh, Wilbert . . . . . Riley  
Carmichael, Clyde S. (S) Seelyville

## Terre Haute

## A

Agee, Ernest B., Jr. . . . 221 S. Sixth  
Alexander, Oliver O.  
301 Rose Disp. Bldg.  
Allen, O. T. . . . 422 Rose Disp. Bldg.  
Anderson, W. C. . . . . 721 Wabash  
Arbonies, William G.  
2150 N. 31st St.  
Asbury, W. D. (S)  
322 Rose Disp. Bldg.  
Ault, Roy . . . . . Tribune Bldg.

## B

Baldrige, William O.  
12 Points State Bk. Bldg.  
Blum, Leon L.  
210 Rose Dispensary Bldg.  
Bopp, Henry, Jr. . . 221 S. Sixth St.  
Bopp, Henry W.  
521 Grand Opera Hse. Bldg.  
Bopp, James . . . . . 2635 Wilson  
Bradley, Stephen C. 916 S. 25th St.  
Bronson, Paul J. . . . 721 Wabash  
Brown, Robert R. . . . 221 S. Sixth

## C

Cajacob, Melville E. . 1000 S. Sixth  
Caldwell, Milton V. . . Tribune Bldg.  
Carpenter, George C. . . . 410 Ohio  
Cavins, Alexander W. . 221 S. Sixth  
Combs, Chas. N. . . . 2516 N. Ninth  
Combs, S. R. . . . . 505 Tribune Bldg.  
Congleton, George C.  
308 Merchants Nat. Bk. Bldg.  
Conklin, J. O. . 500 Rose Disp. Bldg.  
Curry, C. A. . . 506 Rose Disp. Bldg.

## D

Decker, Harvey B. . . 14 Rea Bldg.  
Dyer, Geo. W. . 208 Rose Disp. Bldg.

## E

Eisenlohr, Eugen . . . . 128 S. Sixth

## F

Forsyth, David H. (S)  
215 Merchants Nat. Bk. Bldg.  
Freed, J. E. . . 414 Rose Disp. Bldg.  
Freed, John E., Jr.  
414 Rose Disp. Bldg.

## G

Gerrish, D. A. . . . Rose Disp. Bldg.  
Gilbert, Ivan . 505 Rose Disp. Bldg.  
Gillum, John R. . . . . 221 S. Sixth  
Goodman, Hubert T.  
310 Opera House Bldg.  
Gossom, Donn R. . . Rose Disp. Bldg.

## H

Harkness, Robert G.  
301 Rose Disp. Bldg.  
Haslem, E. R. . 401 Rose Disp. Bldg.  
Haslem, John R. . . . . 221 S. Sixth  
Hoover, Dewey A. . . 14½ N. Third  
Hoover, Jas. J. . . . 14½ N. Third  
Humphrey, Paul E.  
322 Rose Disp. Bldg.  
Hunt, Edgar J. . . . . R. R. 1

## K

Kabel, Robert N. 505 Tribune Bldg.  
Kriebble, William W. . . 221 S. Sixth  
Kunkler, Joseph . . . . 408 Chestnut  
Kunkler, William C.  
212 Merchants Bk. Bldg.

## L

LaBier, Clarence Rollin (S)  
1630 Wabash Ave.  
LaBier, C. R. . . 1630 Wabash Ave.  
Lancet, Robert O. . . 2022 Wabash  
Loewenstein, W. L. 1537 S. 7th St.  
Love, John R. . . . 1601 Eighth Ave.  
Luckett, C. L. 211 Fairbanks Bldg.

## M

McBride, Noel S.  
407 Merchants Nat. Bk. Bldg.  
McCormick, Wilbur C.  
312 Merchants Bk. Bldg.  
McEwen, James W.  
321 Rose Disp. Bldg.  
McLaughlin, Gordon C.  
501 Tribune Bldg.  
Mahoney, Charles L. . 221 S. Sixth  
Malone, Leander A. . . 721 Wabash  
Mason, Lester M.  
312 Merchants Nat. Bk. Bldg.  
Mattox, Don M. . . . 721 Wabash  
Meyn, Werner P. . . . 221 S. Sixth  
Miklozek, John E. . . 1461 S. Seventh  
Miller, Daniel B. (S) . 1603 S. 7th  
Mitchell, A. M. . . . 503 Tribune Bldg.  
Mohr, Ann L. M. . . . . R. R. 1,  
West Terre Haute  
Musselman, G. G. 424 Fourth Ave.

## N-O

Nay, Ernest O. . . . . 221 S. Sixth  
Neudorff, Louis G. 221 S. Sixth St.  
Olipphant, R. W. 410 Tribune Bldg.

## P

Pearce, Roy V. . . . 1440 S. 25th St.  
Pierce, Harold J. . . . . 627 Cherry

## R

Reed, Robert C. 211 Fairbanks Bld.  
Reynolds, Richard J. . 901 S. 25th  
Richart, J. V. . 414 Rose Disp. Bldg.  
Riggs, Floyd C. 2228 Wabash Ave.  
Rubin, Milton M. . . . Tribune Bldg.

## S

Sayers, F. E. . . . . R.R. 5, Box 39A  
Scherb, Burton E. . . 104 N. Seventh  
Schott, Edward J. (S)  
Merchants Nat. Bk. Bldg.  
Schumaker, Robert A.  
211 Fairbanks Bldg.  
Selsam, Etta  
203 Merchants Nat. Bk. Bldg.  
Shanklin, Vernon A.  
202 Fairbanks Bldg.  
Showalter, J. R. . . . 1255½ Maple Rd.  
Siebenmorgen, L. . . 1200 S. Eighth  
Siebenmorgen, P. . . 1200 S. Eighth  
Siegman, Edwin L. . . . 627 Cherry  
Silverman, N. M. . . 1634 S. Seventh  
Sloss, Imit H. . . . 1029 S. Seventh  
Smoots, S. A. . . . 1307 Maple Ave.  
Solomon, Robert D.

Rose Disp. Bldg.

Speas, R. C. . . . 402 Tribune Bldg.  
Spigler, James F.

1402 Wabash Ave.

Stewart, Walter E. . . . 721 Wabash  
Stoelting, J. L. 507 Rose Disp. Bldg.  
Strecker, Wm. L. . . . 2250 Wabash  
Strong, Daniel S. . . . R.R. 7, Box 170  
Sullivan, John M.

2242 College Ave.

## T

Topping, M. C. . . 505 Tribune Bldg.

## U-V

Utterback, Arnold  
R. R. 2, West Terre Haute  
VanArsdall, C. R. . . . 17 S. Ninth  
Voges, Edward C. . . . 1402 Wabash

## W

Weber, Joseph G. S. . . 721 Wabash  
Weinstein, Joseph H. (S)  
221 S. Sixth  
White, Jas. V. . . . . Tribune Bldg.  
Wiedemann, Frank E. (S)  
222 Rose Disp. Bldg.  
Wilkerson, Edw. L. . . 6½ N. Fourth  
Wilson, Fred L. . . . 1501 S. Third  
Wyeth, Chas. (S) . . . . 1100 S. 7th

## X-Y-Z

Zwerner, Paul F.  
12 Points State Bk. Bldg.

Day, Theodore P.  
34329 Lakeshore Blvd.  
Willoughby, Ohio

## WABASH COUNTY

McKay, Robert D. . . . LaFontaine  
Walker, James L. . . . LaFontaine  
Balsbaugh, Geo. . . . N. Manchester  
Brubaker, O. G. (S)

N. Manchester  
Bunker, L. Z. . . . . N. Manchester  
Cook, Chas. E. . . . . N. Manchester  
Seward, Geo. W. . . . . N. Manchester  
Venable, Geo. L. . . . . N. Manchester  
Warvel, Joseph L. (S)

N. Manchester

Kidd, James G. . . . . Roann  
Black, Edgar K. . . . . Wabash  
Dannacher, Wm. D. . . . Wabash



**WABASH COUNTY**

(Continued)

LaSalle, Robert M. . . . . Wabash  
 Mills, John F. . . . . Wabash  
 Pearson, William E. . . . . Wabash  
 Rhamy, Arthur P. . . . . Wabash  
 Steffen, Arthur J. . . . . Wabash  
 Steffen, Julius T. . . . . Wabash  
 Stoops, Jean T. . . . . Wabash  
 Wall, Joseph A. . . . . Wabash  
 Whisler, Frederick M. . . . . Wabash  
 Thompson, Noah H. (S)  
 Elks Home, Bedford, Va.

**WARREN COUNTY**

(See Fountain-Warren)

**WARRICK COUNTY**

Hoover, Peter B. . . . . Boonville  
 Purcell, Jack H. . . . . Boonville  
 Samples, John T. (S) . . . . Boonville  
 Stover, Wendell C. . . . . Boonville  
 Wilson, Paul E. . . . . Boonville  
 Taylor, Lon S. . . . . Elberfeld  
 Faith, Ira L. . . . . Newburgh  
 Wilhelmus, Charles M. . . . Newburgh  
 Springstun, Charles E. . . . Tennyson  
 Zwickel, Ralph E.  
 1782 Wilton Rd., Cleveland, Ohio

**WASHINGTON COUNTY**

Tower, Thomas K. . . . . Campbellsburg  
 Green, William L. (S) . . . . Pekin  
 Apple, Eddie. . . . . Salem  
 Episcopo, A. R. . . . . Salem  
 Gilliatt, James P. . . . . Salem  
 Huckleberry, Irvin E. . . . . Salem  
 Mull, Philip L. (S)  
 Bluegrass Hotel, Louisville, Ky.

**WAYNE-UNION  
COUNTIES**

Clark, Marion E. . . . . Cambridge City  
 Hill, Paul G. . . . . Cambridge City  
 Kenyon, Charles E. . . . . Cambridge City  
 Barton, Willoughby M. . . . Centerville  
 Hutchison, Donald R. . . . . Fountain City  
 McKee, Charles E. (S) . . . . Dublin  
 Zimmerman, Wm. H. . . . . Dublin  
 Marsh, Chester A. . . . . Hagerstown  
 Miller, William A. . . . . Hagerstown  
 Shively, John L. . . . . Hagerstown  
 Dubois, Franklin T. (S) . . . Liberty  
 Lewis, James F. . . . . Liberty  
 McWilliams, William B. . . . Liberty  
 Thompson, Will A. . . . . Liberty  
 Denny, Edgar C. . . . . Milton

**Richmond**

Adney, Frank B.  
 306 Medical Arts Bldg.  
 Ake, Loren  
 410 First Nat. Bk. Bldg.  
 Allen, Hubert E. . . . . 21 S. Eighth  
 Allen, Robert T. . . . . 21 S. Eighth  
 Ballenger, William E.  
 309 Med. Arts Bldg.  
 Blossom, Paul W. . . . . 825 S. A St.

Bond, Charles S. (S) . . . 110 N. 10th  
 Buche, Fredk. P. . . . . 106 S. Seventh  
 Campbell, Perry A.  
 422 Med. Arts Bldg.

Coble, Frank H. . . . . 51 S. Eighth  
 Cook, Norman R.  
 508 First Nat. Bk. Bldg.

Cox, Leon T. . . . . 36 S. Eighth  
 Daggy, James R. . . . . Richmond  
 Daubenheyer, M. F. (S)  
 Richmond State Hospital

Dingle, P. E. . . . . 403 Med. Arts Bldg.  
 Ebbinghouse, Tom. . . . . 98 W. Main  
 Ewbank, J. Nelson  
 Smith-Esteb Hosp.

Griffis, V. C. . . . . 208 Med. Arts Bldg.  
 Hadley, Harvey. . . . . 1st Nat. Bk. Bldg.  
 Harmon, C. J. . . . . 407 Med. Arts Bldg.  
 Harmon, G. H. . . . . 407 Med. Arts Bldg.  
 Hays, George R.  
 401 Second Nat. Bk. Bldg.

Herring, George N.  
 Richmond State Hospital  
 Hill, H. D. . . . . 412 Med. Arts Bldg.  
 Hoffman, Curtis R.  
 405 First Nat. Bk. Bldg.

Hunt, G. J. . . . . Reid Memorial Hosp.  
 Johnson, George M.  
 201 Medical Arts Bldg.

Johnson, P. S. . . . . 215 Med. Arts Bldg.  
 Kime, Charles E. . . . . 810 S. A St.  
 Krueger, Fredk. W. . . . . 45 S. Seventh  
 Laird, Leslie A. . . . . Rich. St. Hosp.  
 Lee, G. W. . . . . 139 Med. Arts Bldg.  
 Ling, John F. . . . . 306 Med. Arts Bldg.

Logan, James Z.  
 203 Second Nat. Bk. Bldg.  
 Loomis, Charles H.  
 Medical Arts Bldg.

Mader, John H. . . . . 808 South A  
 Malcolm, R. . . . . 127 Med. Arts Bldg.  
 Meredith, Elwood J.  
 203 Med. Arts Bldg.

Park, Byron J. . . . . 300 S.W. 5th  
 Ramsdell, Glen A. . . . . 1020 Peacock  
 Ross, Harry P.  
 410 Second Nat. Bk. Bldg.

Ross, James S. . . . . 302 Colonial Bldg.  
 Runge, Paul W. . . . . 1426 E. Main  
 Sage, Charles V. . . . . 47 S. Eleventh  
 Shields Tom S. . . . . 47 S. Eleventh  
 Smith, John R. . . . . 510 S. A St.  
 Snyder, M. C. . . . . 130 Med. Arts Bldg.  
 Stamper, L. A. . . . . 402 Med. Arts Bldg.  
 Stepleton, J. D. . . . . Reid Mem. Hosp.  
 Stillwell, William R.  
 21½ S. 8th St.

Sweet, H. E. . . . . 35 S. 8th St.  
 Taylor, W. R. . . . . 308 Med. Arts Bldg.  
 Vance, W. C. . . . . 136 Med. Arts Bldg.  
 Wanninger, Horace  
 408 Second Nat. Bk. Bldg.

Warrick, Francis B. . . . 1426 E. Main  
 Weinstein, E. B. . . . . 204 Colonial Bldg.  
 Wertenberger, Morris D.  
 Reid Mem. Hosp.

Whallon, Arthur J. . . . . 29 S. Tenth  
 Williams, Paul D. . . . . Rich. St. Hosp.  
 Wisener, G. H. . . . . 213 Med. Arts Bldg.  
 Yencer, Martin W. (S) . . 22 N. 14th

Heck, Rolfe A. . . . . College Corner, O.  
 Shepard, Fred F.  
 College Corner, Ohio

Faulkner, W. H.  
 Meharry Med. Col.,  
 Nashville, Tenn.

**WELLS COUNTY****Bluffton**

Annis, Homer B. . . . . 303 S. Main  
 Aucreman, Charles J. . . . 303 S. Main  
 Brickley, Harry D. . . . . 227 S. Main  
 Brickley, Richard A. . . . . 227 S. Main  
 Buckner, Joy F. . . . . 116 E. Walnut St.  
 Caylor, Harold D. . . . . 303 S. Main  
 Caylor, T. E. . . . . 303 S. Main  
 Cook, Robert G. . . . . 303 S. Main  
 Dorrance, Thos. O. . . . . 303 S. Main  
 Eisaman, Jack L. . . . . 303 S. Main  
 Gillette, Walter R. . . . . 303 S. Main St.  
 Gitlin, Max M. . . . . 121½ E. Market  
 Gitlin, William A. . . . . 121 E. Market  
 Hamilton, O. G. . . . . 227 S. Main  
 Jackson, Charles E. . . . . 303 S. Main  
 Johnston, Robert L. . . . . 303 S. Main  
 Kephart, S. Bruce. . . . . 303 S. Main  
 Mead, Clarence H. . . . . 227 S. Main  
 Mitchell, George S. . . . . 303 S. Main St.  
 Nickel, Allen. . . . . 303 S. Main  
 Sherman, Robert M. . . . . 303 S. Main  
 Talbert, Pierre C. . . . . 303 S. Main  
 Tirman, Wallace S. . . . . 303 S. Main  
 Yoder, Richard P. . . . . 303 S. Main

Gingerick, C. M. . . . . Liberty Center  
 Davidoff, Manuel A. . . . . Ossian  
 Hardin, Wayne E. . . . . Ossian

**WHITE COUNTY**

Galbreth, Jesse P. . . . . Burnettsville  
 Derhammer, George L. . . . Brookston  
 Gish, Howard M. . . . . Brookston  
 Netherton, Clyde R. . . . . Chalmers  
 Houser, Wayne W. . . . . Monon  
 McClure, Stanley E. . . . . Monon  
 Carney, John C. . . . . Monticello  
 Greist, H. W. (S) . . . . Monticello  
 Hibber, Nolan . . . . . Monticello  
 Morris, Warren V. . . . . Monticello  
 Mayfield, Clifford H. (S) . . Reynolds  
 Baynes, Frank L. . . . . Wolcott  
 Forbes, Violet M. Crabbe. . Wolcott

**WHITLEY COUNTY**

Hershey, Ernest A. . . . . Churubusco  
 Hamilton, Thomas. . . . . Columbia City  
 Heritier, Claude J. . . . . Columbia City  
 Kratz, Paul E. . . . . Columbia City  
 Langohr, John. . . . . Columbia City  
 Lehmberg, Otto F. . . . . Columbia City  
 Nolt, Ernest V. . . . . Columbia City  
 Pence, Benjamin F. . . . . Columbia City  
 Thompson, Frank. . . . . Columbia City  
 Garber, Paul A. . . . . South Whitley  
 Huffman, Verlin P. . . . . South Whitley

# MEMBERS OF WOMAN'S AUXILIARY TO THE INDIANA STATE MEDICAL ASSOCIATION

## BY COUNTIES

### ADAMS COUNTY

#### Berne

Beaver, Mrs. N. E. 365 N. Harrison  
Habegger, Mrs. M. L. 505 Clark  
Reusser, Mrs. Amos 256 Sprunger

#### Decatur

Burk, Mrs. J. M. 221 S. Third  
Carroll, Mrs. J. C. R. R. 4  
Duke, Mrs. B. E. 145½ S. Second  
Girod, Mrs. A. H. 1004 W. Monroe  
Kohue, Mrs. G. J. 304 W. Adams  
Parrish, Mrs. Richard 238 S. Second  
Rayl, Mrs. C. C. 334 S. First  
Reppert, Mrs. R. L. Road No. 224  
Smith, Mrs. W. E. 116 S. Third  
Terveer, Mrs. John 415 W. Madison

Zwick, Mrs. H. F. 401 E. Rugg  
Geneva

Lehman, Mrs. H. B. R. R. 1  
Schetgen, Mrs. J. V. Box 236

### ALLEN COUNTY

#### Bluffton

Brickley, Mrs. Harry D. 227 S. Main  
Buckner, Mrs. J. 116 E. Walnut  
Hamilton, Mrs. O. G. 203 E. Central  
Mead, Mrs. C. H. 221 W. Washington

#### Fort Wayne

##### A

Adams, Mrs. J. R. 2538 Fairfield Vw. Pl.  
Aiken, Mrs. A. F. 1927 State  
Aiken, Mrs. N. E. 1923 E. State  
Aldrich, Mrs. Harry 2710 Broadway

##### B

Bailey, Mrs. Paul 1840 Pemberton  
Baltes, Mrs. J. H. 4816 Beaver Ave.  
Bash, Mrs. W. E. 4626 Stratford Road  
Beams, Mrs. Ralph 1801 California  
Beierlein, Mrs. Karl M. Butler Road

Blosser, Mrs. H. V. 1122 W. Washington  
Bolman, Mrs. R. M. Jr. 1038 Maxine Drive  
Bowers, Mrs. G. T. 2609 East Drive

Bowers, Mrs. J. W. 317 E. Washington Blvd.  
Brosius, Mrs. Robert 1530 Lake  
Brown, Mrs. Frederic 906 Woodview

Bruggeman, Mrs. H. O. 1202 W. Washington  
Bryan, Mrs. Franklin A. 1439 Edgewater

Buckner, Mrs. Doster Bass Road  
Buckner, Mrs. George D. 1220 Kensington

Bulson, Mrs. E. L. 4301 Pembroke

##### C

Calvin, Dr. Jessie C. 312 W. Wayne  
Cameron, Mrs. D. F. 2724 N. Clinton

Carlo, Mrs. Ernest 4633 Crestwood  
Cartwright, Mrs. E. L. 529 W. Packard

Catlett, Mrs. M. B. 1143 W. Rudisill  
Clark, Mrs. Wm. 4002 S. Harrison  
Cooney, Mrs. Charles 1168 Westover Road

Cowan, Mrs. James C. Lincoln Highway East  
Craig, Mrs. Richard 4315 Beaver  
Culp, Mrs. John E. 1216 Illsley Drive

##### D

Dahling, Mrs. C. W. 1206 Powers St., New Haven  
Dancer, Mrs. Charles 905 Columbia Ave.

Datzman, Mrs. Richard C. 1405 Pemberton  
Devoe, Mrs. Kenneth Woodburn  
Dunstone, Mrs. H. C. 4134 Indiana

##### E

Eberly, Mrs. Karl C. 1240 W. Rudisill  
Emenbiser, Mrs. D. C. 1040 Lincoln Highway, New Haven

English, Mrs. C. H. 2509 Webster  
Estlick, Mrs. Richard E. 4223 Beaver

##### F

Fichman, Mrs. A. W. 323 W. Berry  
Foy, Mrs. H. W. 1816 Forest Park

##### G

Garton, Mrs. Harry W. Hamilton Road  
Gerding, Mrs. Wm. J. 2943 Central Dr.

Glock, Mrs. M. E. 1913 Forest Park Blvd.  
Glock, Mrs. Wayne R. R. 2  
Goebel, Mrs. Carl W. 4021 Gay  
Graham, Mrs. George M. 3813 Hiawatha

Griest, Mrs. Walter D. 171 Travers Pl.

##### H

Haffner, Mrs. Herman G. 3603 Mulberry Rd.  
Haller, Mrs. Robert 5406 Bluffton Rd.

Hamilton, Mrs. Emory D. 2405 Florida Dr.  
Harvey, Mrs. Harry 2228 Crescent

Hasewinkle, Mrs. A. M. 3544 Kirkland

Hastings, Mrs. Warren C. 1822 Kensington

Hattendorf, Mrs. A. P. 4041 Old Mill Rd.

Havens, Mrs. Russell E. 1845 Kensington

Hoetzer, Mrs. E. M. R. R. 2, New Haven

Hoffman, Mrs. Arthur F. 4223 Indiana

Hoffmann, Mrs. S. P. 234 Maple Grove

Holsinger, Mrs. Robert E. 4617 Indiana

Howe, Mrs. F. L. 3714 Indiana

##### J

Jackson, Mrs. John F. 414 W. Rudisill

Jurgensen, Mrs. Walter 1307 E. Rudisill

##### K

Keck, Mrs. Carleton A. 166 Travers Pl.

Kent, Mrs. Richard N. 2717 East Dr.

Kidder, Mrs. O. T. Lima Rd.  
Kimbrough, Mrs. Robert 5319 Drury Lane

Kissinger, Mrs. Charles C. Veterans Hospital

Kleifgen, Mrs. W. A. 4005 S. Calhoun

Kruse, Mrs. Edward 2301 Fairfield

##### L

Ladig, Mrs. Donald S. 2720 Fairfield

Lehner, Mrs. John 119 Maxine  
Leming, Mrs. Ben L. 3005 N. Anthony

Lemons, Mrs. J. A. 2305 Florida  
Lenk, Mrs. George E. State St. Ex. R. R. 9

Lill, Mrs. J. C. 4221 Buell

Lloyd, Mrs. Robert 3609 S. Anthony

Lohman, Mrs. Robert M. 2138 Owaissa

Loudermilk, Mrs. J. L. 1723 Pemberton

##### M

McArdle, Mrs. Edward G. 1133 Rudisill Blvd.

McBride, Mrs. W. O. 610 Beechwood Circle

McCallister, Mrs. John W. 4215 Drury Lane

McCoy, Mrs. Roy R. 4702 Crestwood Dr.

McDowell, Mrs. G. A. 2322 Forest Park Blvd.

McEachern, Mrs. Cecil 4705 Indiana

McFall, Mrs. J. S. 3322 Garland

McKeeman, Mrs. D. H. 1615 Ardmore

McNairy, Mrs. Donald J. 4522 Beaver

Mackel, Mrs. F. O. 708 Philley

Mendenhall, Mrs. Edgar N. 232 S. Cornell Circle

Mercer, Mrs. S. R. 3235 W. Washington

Meyer, Mrs. T. O. 4438 Wilmette

Michaelis, Mrs. S. C. 1255 Kerte Lane

Miller, Mrs. Carl 457 Oakdale Dr.

Miller, Mrs. H. Paul 417 W. Pontiac



**ALLEN COUNTY**

(Fort Wayne—Continued)

Miller, Mrs. Mahlon . . . 1115 Illsley  
 Miller, Mrs. Orval J. . . 1102 Kensington  
 Miller, Mrs. Richard . . . 1322 W. Foster  
 Miller, Mrs. Wm. J. . . 310 E. Washington  
 Moats, Mrs. Carl . . . 4709 Arlington  
 Moats, Mrs. George . . . 2107 Kensington  
 Moravec, Mrs. Arthur . . . 4711 Old Mill Rd.  
 Mortenson, Mrs. Leland J. . . 1310 N. Foster Parkway  
 Mueller, Mrs. Lawrence . . . 3423 S. Washington Rd.

**N-O**

Nahrwold, Mrs. E. W. . . . 3314 Irvington  
 Nill, Mrs. John . . . 440 W. Fleming  
 O'Rourke, Mrs. Carroll . . . N. Hamilton Rd.  
 Oyer, Mrs. J. H. . . . 2206 Wawonissa

**P**

Painter, Mrs. Donald . . . Washington Center Rd.  
 Parker, Mrs. C. B. . . . 4520 Beaver  
 Perrin, Mrs. Kermit . . . Maysville Rd.  
 Perry, Mrs. Frederic G. . . 709 Kinnaird  
 Phillips, Mrs. John . . . 1217 Roosevelt  
 Ponczek, Mrs. E. J. . . . Monroeville  
 Popp, Mrs. Milton F. . . . 3148 Parnell

**R**

Ranke, Mrs. Henry . . . 3112 Beaver  
 Ray, Mrs. Herbert . . . 325 E. Creighton  
 Rhamy, Mrs. B. W. . . . 4312 Beaver  
 Rissing, Mrs. Walter . . . 3200 Irvington  
 Rockey, Mrs. Noah . . . 2411 Florida Dr.  
 Rodriguez, Mrs. Juan . . . 4720 Crestwood Dr.  
 Roser, Mrs. Arthur . . . Leesburg Rd.  
 Rossiter, Mrs. D. L. . . . 724 Oakdale Dr.  
 Rothberg, Mrs. Maurice . . . 4801 Tocomia  
 Rothschild, Mrs. Charles J. . . 3015 W. Anthony

**S**

Salon, Mrs. Harry . . . 4017 Hiawatha Blvd.  
 Salon, Mrs. N. L. . . . 1024 Kinnaird  
 Savage, Mrs. Robert . . . 1602 Fairhill Rd.  
 Schlademan, Mrs. K. R. . . . 4029 Weisser Park  
 Schlegel, Mrs. Edward . . . 2219 N. Anthony Blvd.  
 Schellhouse, Mrs. Earl M. . . . 3610 Mulberry Rd.  
 Schmidt, Mrs. Eugene E. . . . 1845 Forest Park Blvd.  
 Schmoll, Mrs. Robert J. . . . 2129 Owaissa  
 Schneider, Mrs. Louis A. . . . 4621 South Fork Dr.  
 Scoins, Mrs. W. H. . . . 4301 Taylor  
 Scott, Mrs. H. Vaughn . . . 5224 Fairfield

Sherwood, Mrs. Clarence . . . Lima Rd., Irene Byron San.  
 Sherwood, Mrs. J. V. . . . Lima Rd., Irene Byron San.  
 Shinabery, Mrs. Lawrence . . . 1850 Broadway  
 Singer, Mrs. Elmer . . . 825 Oakdale Dr.  
 Smith, Mrs. G. A. . . . Lincoln Highway, New Haven  
 Smith, Mrs. Phillip L. . . . 3008 S. Lafayette  
 Somers, Mrs. G. H. . . . 227 W. Fleming  
 Stauffer, Mrs. Richard . . . 4120 S. Harrison  
 Stellner, Mrs. Howard A. . . . 4314 S. Calhoun  
 Stier, Mrs. Paul . . . 3807 Fairfield  
 Stumpf, Mrs. E. E. . . . New Haven

**T**

Tennant, Mrs. D. . . . 5021 Fairfield  
 Terrill, Mrs. Richard . . . 4727 Old Mill Rd.  
 Thornton, Mrs. W. E. . . . 601 Oakdale Dr.

**V**

Van Buskirk, Mrs. E. W. . . . 920 Maxine Dr.

**W**

Warfield, Mrs. C. H. . . . 1809 Kensington  
 Weber, Mrs. John R. . . . 1215 Sheridan Court  
 Welty, Mrs. S. G. . . . 509 Oakdale Dr.  
 Wilkins, Mrs. Robert . . . 4839 Old Mill Rd.  
 Williams, Dr. Bernice . . . 3526 N. Washington Rd.  
 Wilson, Mrs. Leslie . . . 2810 S. Wayne  
 Wright, Mrs. William . . . 1834 Pemberton Dr.  
 Wyatt, Mrs. J. L. Jr. . . . 3401 N. Washington Rd.

**Z**

Zehr, Mrs. Noah . . . 301 W. Creighton  
 Zweig, Mrs. Elmer . . . 3365 Garland

**BARTHOLOMEW-BROWN COUNTIES****Columbus**

Adler, Mrs. David Leo . . . 931 Fifth  
 Beggs, Mrs. Lowell F. . . . 2738 Riverside Dr.  
 Carpenter, Mrs. T. D. . . . 2328 Gilmore  
 Davis, Mrs. Marvin R. . . . 2228 Lafayette  
 Fisher, Mrs. Walter S. . . . 906 Franklin  
 Hart, Mrs. Robert B. . . . 1203 16th  
 Hawes, Mrs. Marvin R. . . . 2075 Franklin Dr.  
 Henry, Mrs. Alvin L. . . . 1913 Chestnut  
 Kincaid, Mrs. J. C. . . . 4 Mile House Rd.  
 Macy, Mrs. George . . . 2603 Washington  
 Marr, Mrs. Griffith . . . 1513 17th  
 Norton, Mrs. H. J. . . . 909 Pearl  
 O'Bryan, Mrs. Richard . . . 1602 Washington  
 Overshiner, Mrs. Lyman . . . 1715 Franklin

Rittenman, Mrs. George W. . . . 2209 Caldwell Dr.  
 Rothring, Mrs. Howard E. . . . 2226 Pearl  
 Ryan, Mrs. Wm. J. . . . 2244 Pearl  
 Schmitt, Mrs. R. K. . . . 2639 Riverside Dr.  
 Williams, Mrs. E. W. . . . 1902 Franklin  
 Wissman, Mrs. Wm. L. . . . 1930 Lafayette  
 Yoder, Mrs. Dewey D. . . . 718 Lafayette  
 Zaring, Mrs. Byron K. . . . 2419 Riverside

Dudding, Mrs. Joseph E. . . . Hope  
 Schneider, Mrs. Kenneth . . . Nashville

**BENTON COUNTY**

Taylor, Mrs. W. H. . . . Ambia  
 Atkinson, Mrs. C. W. . . . Boswell  
 Flack, Mrs. O. M. . . . Boswell  
 Leak, Mrs. Robert . . . Boswell  
 Coddens, Mrs. Larry . . . Earl Park  
 Turley, Mrs. Verne L. . . . 501 E. 5th St., Fowler  
 Muller, Mrs. Lullus P. . . . 5608 College Ave., Indianapolis  
 Parker, Mrs. Ernest E. . . . Oxford  
 Scheurich, Mrs. Virgil . . . Oxford  
 Smith, Mrs. Charles G. . . . Otterbein

**BOONE COUNTY**

Schaaf, Mrs. Alvin . . . Jamestown

**Lebanon**

Ballard, Mrs. Robert . . . Country Club Park  
 Coons, Mrs. John . . . Country Club Park  
 Coons, Mrs. Ritchie . . . 1617 Park Dr.  
 Headley, Mrs. Lloyd . . . Country Club Park  
 Honan, Mrs. Paul . . . Elmwood Addition  
 Kern, Mrs. Clarence . . . 423 E. Main  
 Rainey, Mrs. E. A. . . . 912 N. Meridian  
 Spieth, Mrs. William . . . Country Club Park  
 Weddle, Mrs. Charles . . . 1210 N. East  
 Wiseheart, Mrs. Robert . . . Country Club Park

Bassett, Mrs. Clancy . . . Thorntown  
 Gregg, Mrs. Edwin . . . Thorntown  
 Lovett, Mrs. Harvey . . . Whitestown  
 Bailey, Mrs. Lawrence . . . Zionsville

**CARROLL COUNTY**

Van Kirk, Mrs. John . . . Burlington

**Delphi**

Brown, Mrs. Tom . . . W. North  
 Bryne, Mrs. John . . . Franklin  
 Crampton, Mrs. Chas. . . . Monroe  
 Maggart, Mrs. Ralph . . . R. R. 3  
 Wagoner, Mrs. John . . . W. North  
 Wagoner, Mrs. Geo. W. . . . W. Summit  
 Adams, Mrs. Max . . . Flora  
 Brookie, Mrs. Roger . . . Flora  
 McLaughlin, Mrs. James . . . Flora

**CASS COUNTY****Galveston**

Dutchess, Mrs. C. W.  
Lybrook, Mrs. D. E. . . . . R. R. 2

**Logansport**

Adamski, Mrs. M. S. . . . . 614 17th  
Bailey, Mrs. Earl W. . . . . 2522 North  
Ballard, Mrs. Charles A. . . . . R. R. 4  
Bradfield, Mrs. John . . . . . R. R. 4  
Cooper, Mrs. Thomas L. . . . . 2904 North

Crandall, Mrs. W. E. . . . . 1330 E. Broadway  
Davis, John . . . . . 2119 North  
Fitzgerald, Mrs. Brice . . . . . 1930 High  
Hall, Mrs. Bernard R. . . . . 1707 E. Broadway

Hedde, Mrs. E. L. . . . . R. R. 5  
Hillis, Mrs. L. J. . . . . 2508 E. Broadway  
Holloway, Mrs. W. A. . . . . 200 Eel River

Holmes, Mrs. Will W. . . . . R. R. 4  
Jewell, Mrs. E. B. . . . . 3019 S. Pennsylvania

Jones, Mrs. J. Carl . . . . . R. R. 3  
Maxwell, Mrs. J. B. . . . . 1119 High  
Morrical, Mrs. R. J. . . . . 920 Michigan  
Morrow, Mrs. G. W. . . . . Longcliff State Hospital

Schenck, Mrs. Foss . . . . . Longcliff State Hospital  
Shultz, Mrs. Harry . . . . . 412½ Fourth  
Viney, Mrs. Charles . . . . . R. R. 4  
Wilson, Mrs. Paul . . . . . R. R. 5  
Winter, Mrs. Donald K. . . . . 2541 E. Broadway

Newcomb, Mrs. W. K. . . . . Royal Center  
Flanagan, Mrs. E. P. . . . . Walton

**CLARK COUNTY****Charlestown**

Bottorff, Mrs. David C. . . . . 493 Harrison  
Goodman, Mrs. Eli . . . . . 802 Market  
Patterson, Mrs. Cecil L. . . . . 1415 Tunnel Mill Rd.

Willner, Mrs. Alan . . . . . 113 S. Sunset, Clarksville  
Greene, Mrs. Wm. R. . . . . Henryville

**Jeffersonville**

Adair, Mrs. Sam . . . . . R. R. 1, Utica Pike  
Bruner, Mrs. Ralph W. . . . . 804 E. Court

Buckley, Mrs. E. P. . . . . 14 Blanchel Terrace  
Carlberg, Mrs. Dale L. . . . . 2 Blanchel Terrace

Carney, Mrs. J. T. . . . . 203 Sparks  
Clark, Mrs. Wm. B. Jr. . . . . 21 Blanchel Terrace  
Dare, Mrs. Lee . . . . . 215 Sparks

Forsee, Mrs. Norman . . . . . 506 E. Charlestown  
Graham, Mrs. Lula B. (W) . . . . . 713 E. Maple

Huoni, Mrs. John S. . . . . 6 Blanchel Terrace  
Isler, Mrs. Nathaniel . . . . . 901 Morningside Dr.

Weems, Mrs. Mallory P. . . . . Hopkins Dr.

Witt, Mrs. W. R. . . . . 968 E. Spring St., New Albany

**Sellersburg**

Regan, Mrs. George . . . . .  
Sturgis, Mrs. Donald G. . . . .  
Vandevent, Mrs. Arthur . . . . .

**CLAY COUNTY****Clay City**

Bond, Mrs. Walter C. . . . . 8th and White  
Glosson, Mrs. Jack R. . . . . 316 N. Main  
Ward, Mrs. H. H. . . . . Coalmont

**Brazil**

Maurer, Mrs. J. Frank . . . . . 6 E. Park  
Maurer, Mrs. Robert M. . . . . 1115 N. Meridian  
Palm, Mrs. John M. . . . . 27 E. Church  
Sourwine, Mrs. Clint C. . . . . 141 N. Walnut  
Weaver, Mrs. Timothy M. . . . . R. R. 2  
Webster, Mrs. Robert K. . . . . 25 N. Beech  
Wood, Mrs. Opal L. . . . . 428 E. Blaine

**DAVIESS-MARTIN COUNTIES**

Rohrer, Mrs. James . . . . . Elnora

**Loogootee**

Chattin, Mrs. Robt. . . . .  
Lett, Mrs. E. B. . . . .  
McCracken, Mrs. J. O. . . . . Montgomery

**Odon**

Colenian, Mrs. H. G. . . . .  
Sears, Mrs. Don . . . . .  
Maschmeyer, Mrs. Robt. . . . . Shoals

**Washington**

Blazey, Mrs. A. G. . . . . 7 E. Walnut  
Burress, Mrs. B. O. . . . . Pine Court  
Chattin, Mrs. Vance . . . . . Green Acres  
Farris, Mrs. John . . . . . 411 William  
Fox, Mrs. Philip . . . . . Green Acres  
Lindsay, Mrs. H. B. . . . . Bedford Rd.  
Lloyd, Mrs. C. A. . . . . N. E. 2nd  
McKittrick, Mrs. Jack . . . . . Green Acres  
McKittrick, Mrs. W. O. . . . .

McNaughton, Mrs. L. M. . . . . 812 E. Main

Norton, Mrs. Horace . . . . . 511 Hefron  
Rang, Mrs. Arthur . . . . . 211 E. Ninth  
Rang, Mrs. Robert . . . . . 214 E. Ninth  
Schroeder, Mrs. Roland . . . . . N. E. 1st  
Shields, Mrs. Harry . . . . . Bedford Rd.  
Smoot, Mrs. Brayton . . . . . Troy Rd.  
Shafer, Mrs. Wm. C. . . . . 221 N. E. 9th

**DEARBORN-OHIO COUNTIES****Aurora**

Olcott, Mrs. Charles W. . . . . 422 Sunnyside

Stewart, Mrs. Omer H. . . . . Second and Bridgeway

McNeeley, Mrs. Matthew J. . . . . Dillsboro  
Elliott, Mrs. John C. . . . . Guilford

**Lawrenceburg**

Fagely, Mrs. William J. . . . . 57 Oakley  
Houston, Mrs. Fred D. . . . . East High  
Pfeifer, Mrs. James M. . . . . 550 Ludlow  
Streck, Mrs. Francis A. . . . . Ridge Ave.  
Vail, Mrs. George A. . . . . Ludlow

**Rising Sun**

Fessler, Mrs. Gordon . . . . .  
Manley, Mrs. Charles N. . . . .

**DECATUR COUNTY**

Tremain, Mrs. M. A. . . . . Adams

**Greensburg**

Acher, Mrs. Robert P. . . . . 446 E. Washington  
Blemker, Mrs. Russell . . . . . 332 E. North  
Callaghan, Mrs. W. C. . . . . Lincoln Park R. R. 1  
Dickson, Mrs. Dale D. . . . . 825 N. Broadway

Miller, Mrs. James C. . . . . 178 N. Mich.  
McKee, Mrs. Harry S. . . . . 190 N. Mich.  
Morrison, Mrs. J. Trevor . . . . . N. Mich.  
Overpeck, Mrs. Charles . . . . . 728 N. Broadway

Sallee, Mrs. Wm. T. . . . . 245 S. Mich.

Porter, Mrs. Earl A. . . . . Westport

**DELAWARE-BLACKFORD COUNTIES****Albany**

Brown, Mrs. Stewart D. . . . . Albany  
Puterbaugh, Mrs. Karl . . . . . Albany  
Craigmile, Mrs. Thomas K. . . . . Cowan

**Daleville**

Hurley, Mrs. John . . . . .  
Rutledge, Mrs. Jean . . . . .  
Tucker, Mrs. O. A. . . . .

**Gaston**

Downard, Mrs. Leland F. . . . .  
Montgomery, Mrs. Lall . . . . .  
Langsdon, Mrs. Fred . . . . .

Douglas, Mrs. William Montpelier

**Muncie**

Adams, Mrs. William B. . . . . W. Jackson St. Pike  
Alvey, Mrs. Charles R. . . . . 3001 Torquay Rd.  
Anthony, Mrs. Harvey M. . . . . 822 W. Charles

**B**

Ball, Mrs. Clay A. . . . . 1015 Linden  
Ball, Mrs. Lucius L. . . . . Minnetriste Blvd.  
Ball, Mrs. Philip . . . . . 3020 Godman  
Bibler, Mrs. Henry . . . . . Parkway Dr.  
Botkin, Mrs. Clyde G. . . . . 2904 Riverside Ave.



# DELAWARE-BLACKFORD COUNTIES

## (Muncie—Continued)

Botkin, Mrs. Tom. 1007 W. North  
Bowles, Mrs. Herman 324 N. Vine  
Bowles, Mrs. John H. 408 Wayne  
Brown Mrs. Karl T., 905 E. Adams  
Brown, Mrs. Leland. 2012 W. 9th  
Brown, Miss Nellie Gates  
Brown, Mrs. Robt. L. 517 N. Elm  
Brown, Mrs. Tom. 2119 W. 10th  
Butterfield, Mrs. Robert  
1002 W. Gilbert

## C

Clauser, Mrs. Eldo. 1 Briar Rd.  
Clevenger, Mrs. Joseph H.  
3124 University Ave.  
Cole, Mrs. Russell E.  
431 W. Howard  
Covalt, Mrs. Wendell  
1525 N. Tillotson Ave.  
Cure, Mrs. Elmer T.  
913 University Ave.

## D

Davis, Mrs. Ed. C. 45 Warwick Rd.  
Deutsch, Mrs. Wm. 2100 Petty Rd.  
Dunn, Mrs. Farrell W.  
1416 Wheeling Ave.

## E-F

Egbert, Mrs. C. H. 2010 S. Vine  
Eissman, Mrs. Eugene,  
211 Alden Rd.  
Funk, Mrs. John  
3700 Peachtree Lane

## G

Garling, Mrs. L. C. 37 Briar Rd.  
Gilbert, Mrs. N. C. Granville Pike  
Gill, Mrs. Tom. 2600 W. Jackson  
Greiber, Mrs. Marvin 310 Riley Rd.  
Gustafson, Mrs. Milton H.  
230 Stradling Rd.

## H-I

Hall, Mrs. O. A. 3121 W. Gilbert  
Hayes, Mrs. T. R. 920 W. North  
Henderson, Mrs. Ramon  
75 Warwick Rd.  
High, Mrs. Ralph  
2825 University Ave.

Hill, Mrs. Frank. 321 Calvert  
Hill, Mrs. Howard 106 Berwyn Rd.  
Hill, Mrs. Robert  
State Rd. No. 3 South  
Hostetter, Mrs. I. S. 300 Winthrop  
Hurley, Mrs. Anson 3010 Riverside  
Imhof, Mrs. J. D.  
307 Granville Ave.

## K

Kammer, Mrs. Howard  
919 W. Main  
Kemper, Mrs. Arthur  
600 E. Wash.  
Kirshman, Mrs. F. E. 41 Briar Rd.  
Kuder, Mrs. Howard F.  
1208 N. Walnut

## M

Mason, Mrs. L. R.,  
3013 Oaklyn Ave.  
McClellan, Mrs. John 331 E Adams  
McCoy, Mrs. George 222 E. Adams  
McClintock, Mrs. James A.  
611 Beechwood  
Molloy, Mrs. W. J., 619 E. Charles

McDowell, Mrs. Fletcher  
500 W. Main

Morris, Mrs. J. W.  
222 Stradling Rd.  
Moss, Mrs. M. J. 2526 W. Main

## O

Owens, Mrs. O. W. 2600 Godman  
Owens, Mrs. Richard R.  
2316 Godman  
Owens, Mrs. Thomas  
608 E. Charles

## P-Q

Peacock, Mrs. Robert St. Rd. 67 N.  
Poland, Mrs. U. G. 303 E.  
Washington  
Quick, Mrs. Wm.  
2009 University Ave.

## R

Rettig, Mrs. Arthur  
611 W. Howard  
Rivers, Mrs. Glynn  
1334 N. Walnut

## S

Schulhof, Mrs. M. G.  
1408 Wheeling Ave.  
Silvers, Mrs. J. C. 319 S. Franklin  
Silvers, Mrs. J. M. 220 W. Adams  
Smith, Mrs. J. Sylvester,  
1006 E. 1st  
Stanley, Mrs. John R.  
2505 W. Gilbert  
Stocking, Mrs. Bruce,  
3014 Amhurst

## T

Tindal, Mrs. E. F. 423 W. Jackson  
Tomlin, Mrs. Hugh M. 921 W. Main  
V-W  
Venis, Mrs. Kemper. 502 Wade  
Wadsworth, Mrs. W. W.  
306 E. Jackson

Williams, Mrs. J. H. 905 W. North  
Wright, Mrs. C. H. 715 Rex  
Y  
Young, Mrs. G. S. 114 Berwyn Rd.

Hinchman, Mrs. Jean. Parker  
Moore, Mrs. Will C. Yorktown

# DUBOIS COUNTY

Backer, Mrs. Henry George  
Ohio St., Ferdinand

## Huntingburg

Amini, Mrs. S. 105 Van Buren  
Bretz, Mrs. John 222 Van Buren  
Bretz, Mrs. W. D. 214 Fourth  
Stork, Mrs. Harvey K. 523 1st  
Williams, Mrs. Fielding 511 Geiger  
Williams, Mrs. Flora 511 Geiger

## Jasper

Casper, Mrs. John 802 W. 6th  
Casper, Mrs. Joseph  
Terrace Heights  
Greenburg, Mrs. Rolland E.  
738 W. 13th

Heck, Mrs. Martin C. 388 W. 15th  
Held, Mrs. George A.  
Terrace Heights  
Klamer, Mrs. Charles H.  
424 W. 6th

Wagner, Mrs. Arthur, R.F.D. 5

# ELKHART COUNTY

## Bristol

Neidballa, Mrs. E. G. R.F.D. 1  
Patrick, Mrs. G. B. R.F.D. 1  
Schlosser, Mrs. H. C. Seven Gables

## Elkhart

Bender, Mrs. R. L. 125 N. Riverside  
Billings, Mrs. Elmer 327 Emerald  
Bloom, Mrs. George R.  
130 Glendale

Bolin, Mrs. Robert S.  
1853 East Beardsley

Bowdoin, Mrs. George E.  
1029 West Lexington

Compton, Mrs. Walter A.  
2225 Greenleaf Blvd.

Conklin, Mrs. R. L. 1906 E. Jackson  
Cormican, Mrs. Herbert L.  
1621 E. Jackson

Crandall, Mrs. L. A., Jr.  
Crandall's Pond, R.F.D. 3

Elliot, Mrs. L. A. 2001 Stevens  
Elliot, Mrs. Thomas A.  
2001 Stevens

Fleming, Mrs. Claude F.  
229 W. Jackson

Fleming, Mrs. J. Millard  
2220 E. Jackson

Horswell, Mrs. R. G.  
1629 E. Jackson

Hull, Mrs. A. W. 905 Strong  
Hunn, Mrs. M. F. 202 W. Beardsley  
Kintner, Mrs. Burton E.  
3520 E. Jackson

Kistner, Mrs. Arthur W.  
102 W. Beardsley

Koehler, Mrs. Elmer G. R.F.D. 5  
Logan, Mrs. Richard. 706 Fulton

Lundt, Mrs. Milo O. 519 S. 2nd  
Markel, Mrs. I. J. 215 W. Franklin

Mendez, Mrs. Carlos  
325 Superior Blvd.

Miller, Mrs. Galen 903 W. Franklin  
Miller, Mrs. Hugh A., Jr.  
309 E. Crawford

Miller, Mrs. Sam T. 1230 Prairie  
Mininger, Mrs. Edward P.  
413 W. Franklin

Mishkin, Mrs. Irving  
217 N. Riverside Dr.

Paff, Mrs. Wm. A. 2601 E. Jackson  
Paine, Mrs. George D. 329 Meisner  
Pancost, Mrs. Vernon  
160 Riverview Ave.

Possolt, Mrs. Thomas  
2806 E. Jackson

Rohr, Mrs. Joe 1425 E. Jackson  
Rupe, Mrs. L. O. 116 W. Dinehart  
Sears, Mrs. M. Maywood  
R.F.D. 3, West Indiana

Spray, Mrs. Page. 658 Kilbourne  
Stauffer, Mrs. W. A. 701 Strong  
Stout, Mrs. R. B. 1501 Greenleaf  
Stubbins, Mrs. William  
R.F.D. 1, Dunlap

Swihart, Mrs. Homer R.  
220 Meisner

Swihart, Mrs. L. F.  
2120 Broadmoor Dr.

Todd, Mrs. David D.  
2001 E. Jackson

Wilson, Mrs. O. E.  
2505 Greenleaf Blvd.

Work, Mrs. James A., Jr.  
4 St. Joseph Manor

Yoder, Mrs. C. Richard  
130 N. Corona

**ELKHART COUNTY****(Continued)****Goshen**

Amstutz, Mrs. H. C. 2001 S. Main  
 Bender, Mrs. C. K. 624 S. 5th  
 Bigler, Mrs. Fredrick 307 S. 7th  
 Freeman, Mrs. F. M. 309 E. Wash.  
 Hostetler, Mrs. C. M. 1602 S. 8th  
 Kelly, Mrs. William R. 310 E. Monroe  
 Kinzie, Mrs. D. K. 406 Sunset Blvd.  
 Martin, Mrs. Floyd S. R.F.D. 5  
 Nelson, Mrs. D. Chester 1210 S. 8th  
 Simmons, Mrs. Lloyd H. 606 S. 3rd  
 Turner, Mrs. John R.F.D. 2  
 Vander Bogart, Mrs. Harry E. 1411 S. 8th  
 Yoder, Mrs. Albert C. 816 S. 6th  
 Norris, Mrs. Ernest Middlebury

**Nappanee**

Fleetwood, Mrs. R. A. 151 E. Van Buren  
 Kendall, Mrs. F. M. 801 E. Market  
 Price, Mrs. Douglas W. 458 N. Madison  
 Price, Mrs. M. Delbert 451 N. Hartman  
 Slabaugh, Mrs. L. M. 402 N. Main  
 Slabaugh, Mrs. J. S. 111 N. Main  
 Fosbrink, Mrs. E. L. Syracuse  
 Abel, Mrs. Robert Wakarusa  
 Amick, Mrs. Charles L. Wakarusa  
 Hannah, Mrs. Jack W. Wakarusa

**FAYETTE-FRANKLIN COUNTIES****Brookville**

Foreman, Mrs. Walter A. 617 Main  
 Smith, Mrs. H. N. 812 Main  
 Glazer, Mrs. Robert 814 Main  
 Seal, Mrs. Perry F. 901 Main  
 Hoeger, Mrs. H. R. Franklin St.

**Connersville**

Ashworth, Mrs. L. Neff 2027 Indiana Ave.  
 Booher, Mrs. Irvin E. 1609 Virginia Ave.  
 Brookman, Mrs. Robert E. 2750 Grand Ave.  
 Clark, Mrs. Helen Nevin 401 Western Ave.  
 Ellis, Mrs. George M. 516 W. 29th  
 Fettig, Mrs. Lucille 1609 Virginia Ave.  
 Fruth, Mrs. Virgil J. 1603 Virginia Ave.  
 Gregg, Mrs. Albert F. 855 Lincoln Ave.  
 Kemp, Mrs. W. Alfred 403 W. 28th  
 Leffel, Mrs. J. S. 1810 Indiana Ave.  
 Lockhart, Mrs. Jack M. 2918 Vermont Ave.  
 Metcalf, Mrs. Henry C. 1805 Virginia Ave.  
 Morrow, Mrs. Roy D. 1718 Virginia Ave.  
 Mountain, Mrs. Francis B. 1720 Virginia Ave.  
 Moore, Mrs. Hollis 126½ W. 11th  
 Smelser, Mrs. Herman W. 2530 Grand Ave.  
 Watterson, Mrs. Gerald T. 1704 Virginia Ave.

**FLOYD COUNTY**

Engleman, Mrs. H. K. Georgetown

**Jeffersonville**

Baxter, Mrs. S. M. Centralia  
 McCullough, Mrs. J. Y. Centralia  
 Sloan, Mrs. H. P. Lincoln Heights  
 Allen, Mrs. Fred K. 2015 Lindberg  
 Baker, Mrs. A. M. 2523 Glenwood  
 Baxter, Mrs. J. W., Jr. 426 Woodrow Ave.  
 Briscoe, Mrs. C. E. 1413 E. Spring  
 Brown, Mrs. K. H. 1654 Hedden Park  
 Byrn, Mrs. Howard 330 Beharrel Ave.  
 Davis, Mrs. Parvin Paoli Pike  
 Day, Mrs. George Hausfelt Lane  
 Edwards, Mrs. W. F. 615 Beharrel Ave.  
 Garner, Mrs. Wm. H. 922 E. Spring

Hauss, Mrs. A. P. Silver Hills  
 Hess, Mrs. Patrick Lily Lane  
 Higgins, Mrs. John Old Vincennes Rd.  
 LaFollette, Mrs. Robert E. 2510 Glenwood Park  
 Leuthart, Mrs. C. P. 1410 E. Spring  
 Pace, Mrs. Jerome Silvercrest, Old Vincennes Rd.  
 Paris, Mrs. John M. 2003 Lindberg Ct.  
 Pierson, Mrs. Percy R. 1430 Silver  
 Pierce, Mrs. Gene S. Millerwood Dr.

Robertson, Mrs. A. N. 323 E. 9th  
 Streepey, Mrs. Jefferson 1919 Depauw Ave.  
 Tyler, Mrs. F. T. Daisy Lane  
 Voyles, Mrs. Harry 425 Beharrel Ave.  
 Weaver, Mrs. W. W. 1104 E. Spring  
 Wohlfeld, Mrs. Gerald Silvercrest, Old Vincennes Rd.  
 Wolfe, Mrs. Nelson A. 1117 E. Spring  
 Bird, Mrs. J. E. 1308 E. Spring  
 Rogers, Mrs. S. T. 1017 E. Spring  
 Winstandley, Mrs. Wm. 815 Vincennes  
 Schoen, Mrs. Philip 1825 State

**FULTON COUNTY**

Miller, Mrs. Virgil C. Akron  
 Stinson, Mrs. Arthur E. Athens  
 Bowers, Mrs. Harvey 2552 W. Leland Ave., Chicago 25  
 Kelsey, Mrs. Lawrence E. Kewanna  
 Kranzing, Mrs. Kenneth K. Kewanna

**Rochester**

Dielman, Mrs. Franklin C. 920 Jefferson  
 Glackman, Mrs. John C., Sr. W. 6th  
 Herendeen, Mrs. Elbie V. 317 W. 7th  
 King, Mrs. Milo O. 110½ E. 8th  
 Knotts, Mrs. Slater 328 Clay  
 Richardson, Mrs. Chas. L. 506 Pontiac

Rowe, Mrs. Howard H. 417 W. 9th  
 Stinson, Mrs. Dean K. 1318 Main

**GIBSON COUNTY**

Geick, Mrs. R. G. 207 N. Main, Ft. Branch  
 Hollis, Mrs. W. H. 607 E. Locust, Ft. Branch  
 Arthur, Mrs. H. M. Hazelton  
 Clark, Mrs. C. M. 511 W. Columbia, Oakland City  
 Turner, Mrs. M. A. 322 W. Columbia, Oakland City  
 Wood, Mrs. R. W. 628 W. Oak, Oakland City  
 Geller, Mrs. S. N. Owensville  
 Montgomery, Mrs. J. R. Owensville  
 Strickland, Mrs. K. S. Owensville  
 Arthur, Mrs. M. L. Patoka

**Princeton**

Alexander, Mrs. H. H. 427 W. State  
 Carpentier, Mrs. H. F. 319 E. State  
 Folck, Mrs. J. K. 530 N. Hart  
 Graves, Mrs. O. M. 116 E. Spruce  
 McCarty, Mrs. Virgil 403 W. Spruce  
 McElroy, Mrs. R. S. 404 W. Walnut  
 Peck, Mrs. J. F. Outer W. Monroe  
 Weitzel, Mrs. R. E. 309 W. Spruce

**GRANT COUNTY**

Mallott, Mrs. Fred Converse  
 Garrison, Mrs. L. G. 305 E. S. "C" St., Gas City  
 Koontz, Mrs. William A. 315 E. S. "A" St., Gas City

**Marion**

Abel, Mrs. Charles Wabash Ave.  
 Alderfer, Mrs. Henry 806 W. 1st  
 Avers, Mrs. W. W. 820 Jeffras Ave.  
 Bloom, Mrs. A. Ward Quarry Rd., R.R. 1  
 Comeau, Mrs. Wm. Hickory Hills  
 Daniels, Mrs. George 106 N. East  
 Davis, Mrs. Merrill S. 723 Euclid Ave.  
 Davis, Mrs. Richard 1321 W. 4th  
 Diamond, Mrs. Leo L. 617 Spencer Ave.  
 Eckhart, Mrs. G. G. Northwood  
 Eshleman, Mrs. L. H. 2923 S. Washington

Fisher, Mrs. P. J. 1714 E. 34th  
 Ganz, Mrs. Max 804 W. 3rd  
 Hummel, Mrs. R. M. Shady Hills  
 McIlwain, Dr. Eleanor 2107 S. Botts

Powell, Mrs. J. P. 127 River Dr.  
 Renbarger, Mrs. Lester Wabash Pike

Rhorer, Mrs. John G. Wabash Ave.  
 Simmons, Mrs. F. H. 520 Whites Ave.

Skomp, Mrs. C. S. 1123 Euclid Ave.  
 Warren, Mrs. C. B. 803 W. 6th  
 Wicker, Mrs. Eugene 1119 W. 4th  
 Wiersma, Mrs. Alvin 514 Wabash Ave.

Young, Mrs. Robert, 1911 S. Botts

King, Mrs. P. C. Swayzee  
 Taylor, Mrs. E. C. Upland  
 Rifner, Mrs. E. S. Van Buren



**HAMILTON COUNTY**

Donahue, Mrs. C. M. . . . . Carmel  
 Havens, Mrs. Oscar . . . . . Cicero  
 Ambrose, Mrs. J. C. . . . . Noblesville  
 Harris, Mrs. Robert . . . . . Noblesville  
 Hash, Mrs. J. S. . . . . Noblesville  
 Kraft, Mrs. H. C. . . . . Noblesville  
 Shanks, Mrs. Ray . . . . . Noblesville  
 Shonk, Mrs. H. W. . . . . Noblesville  
 Southard, Mrs. Carl . . . . . Noblesville  
 Campbell, Mrs. Sam . . . . . Noblesville  
 Connoy, Mrs. Andrew . . . . . Westfield  
 Connoy, Mrs. Leo . . . . . Westfield

**HANCOCK COUNTY****Charlottesville**

Johnston, Mrs. W. R.  
 Scott, Mrs. Robert

**Fortville**

Ferrell, Mrs. J. E. . . . . 305 N. Merrill  
 Manifold, Mrs. Harold  
 Navin, Mrs. H. K.

**Greenfield**

Allen, Mrs. Joseph . . . . . 17 E. South  
 Endicott, Mrs. Wayne . . . . . N. East  
 Gibbs, Mrs. Charles . . . . . 203 E. North  
 Gill, Mrs. D. D. . . . . . 328 Park  
 Henn, Mrs. Anthony  
 Hunter, Mrs. Donn . . . . . N. East  
 Kinneman, Mrs. R. E. . . . . 236 W. North  
 Rariden, Mrs. Hazel (L.B.) . . . . . 502 N. State  
 Vingus, Mrs. Bronie . . . . . 705 N. State  
 Woods, Mrs. James R., Jr. . . . . 715 N. East  
 Pierson, Mrs. Thomas . . . . . New Palestine  
 Kuhn, Mrs. Robert . . . . . Wilkinson  
 Treese, Mrs. Nelle . . . . . Wilkinson

**HENDRICKS COUNTY**

Foltz, Mrs. Lloyd . . . . . Brownsburg  
 Scudder, Mrs. A. N. . . . . Brownsburg  
 Elliot, Mrs. Paul . . . . . Danville  
 Koch, Mrs. Elmer . . . . . Danville  
 Price, Mrs. Ernest . . . . . Danville  
 Terry, Mrs. Lloyd . . . . . Danville  
 Ellis, Mrs. L. Hall . . . . . Lizton  
 Gibbs, Mrs. Joseph . . . . . Martinsville  
 Scamahorn, Mrs. Malcom . . . . . Pittsboro  
 Scamahorn, Mrs. Oscar T. . . . . Pittsboro  
 Cohen, Mrs. Irving . . . . . Plainfield  
 Stafford, Mrs. William C. . . . . Plainfield

**HENRY COUNTY**

Zimmerman, Mrs. W. H. . . . . Dublin  
 Dreyer, Mrs. Ralph . . . . . Knightstown  
 Matychowiak, Mrs. F. A. . . . . Knightstown  
 Shallenberger, Mrs. H. R. . . . . Modoc  
 Marshall, Mrs. L. C. . . . . Mt. Summit  
 New Castle  
 Amos, Mrs. Robt. L. . . . . 924 Lincoln Ave.  
 Bitler, Mrs. C. C. . . . . 603 S. 11th  
 Blaize, Mrs. J. A. . . . . 1008 Broad  
 Bledsoe, Mrs. J. G. . . . . 319 S. 14th

Burnett, Mrs. A. B. . . . . 1201 S. Main  
 Canaday, Mrs. C. E. . . . . 1411 Church  
 Craig, Mrs. Alex F. . . . . Route 2  
 Davies, Mrs. Robert R. . . . . Broadway Apts.  
 Fisher, Mrs. John . . . . . 438 S. 11th  
 Foster, Mrs. Ray . . . . . 420 N. Main  
 Harrison, Mrs. B. L. . . . . 223 Bundy Ave.  
 Heilman, Mrs. William C. . . . . 1111 Audubon Rd.  
 Hill, Mrs. Kenneth G. . . . . 100 Leland  
 Itermann, Mrs. G. E. . . . . 925 Mourer  
 Kennedy, Mrs. W. U. . . . . 701 S. 14th  
 Life, Mrs. Homer L. . . . . 1015 W. Broad  
 McDonald, Mrs. Frank C. . . . . 524 S. 11th  
 McElroy, Mrs. James S. . . . . 1213 Audubon Rd.  
 Poston, Mrs. C. L. . . . . 720 S. 11th  
 Saint, Mrs. Wm. K. . . . . 2709 S. 19th  
 Smith, Mrs. Robt. A. . . . . 1229 Lincoln  
 Stout, Mrs. Walter M. . . . . 1103 Audubon Rd.  
 Thorne, Mrs. Charles E. . . . . 1119 S. Main  
 Wiggins, Mrs. D. S. . . . . 219 S. 12th  
 Wiggins, Mrs. George, 403 N. Main

Robertson, Mrs. Wm. . . . . Spiceland

**HOWARD COUNTY**

Denton, Mrs. Larkin . . . . . Greentown  
 Shoup, Mrs. H. P. . . . . Greentown

**Kokomo**

Adams, Mrs. C. J., . . . . . 1216 W. Superior  
 Alward, Mrs. J. H. . . . . 401 W. Walnut  
 Ault, Mrs. C. H. . . . . 321 E. Walnut  
 Boughman, Mrs. J. D. . . . . 1515 W. Jefferson  
 Bowers, Mrs. C. C. . . . . 1530 W. Taylor  
 Bowers, Mrs. C. B. . . . . 421 Morningside  
 Bowers, Mrs. J. A. . . . . 1535 W. Jefferson  
 Bruegge, Mrs. T. J. . . . . 1414 Kingston  
 Clarke, Mrs. Elton . . . . . 1400 W. Sycamore  
 Conley, Mrs. T. M. . . . . 1016 W. Superior  
 Craig, Mrs. R. A. . . . . 113 Leafy Lane  
 Craig, Mrs. Ruben . . . . . W. Jefferson Rd.  
 Crawford, Mrs. T. R. . . . . 908 W. Superior  
 Cuthbert, Mrs. F. S. . . . . 1027 W. Walnut  
 Earl, Mrs. M. M. . . . . 409 W. Taylor  
 Ferry, Mrs. P. J. . . . . 1027 W. Sycamore  
 Golper, Mrs. M. N. . . . . 1021 W. Mulberry

Good, Mrs. R. P. . . . . 417 Conradt  
 Halfast, Mrs. Richard S. . . . . Webster  
 Hutto, Mrs. O. D. . . . . 1012 W. Walnut  
 Hutto, Mrs. W. H. . . . . 211 Conradt  
 Jewell, Mrs. G. M. . . . . 1525 W. Walnut  
 Kratzer, Mrs. E. F. . . . . 320 E. Walnut  
 Lung, Mrs. Bruce . . . . . 115 Conradt  
 McIndoo, Mrs. R. E. . . . . 820 W. Walnut  
 Meiner, Mrs. J. A. . . . . 924 W. Wash.  
 Morford, Mrs. Guy . . . . . 1017 W. Superior  
 Morrison, Mrs. W. R. . . . . 413 Conradt

Murray, Mrs. E. C. . . . . 2200 S. Webster  
 Paris, Mrs. D. W. . . . . 2417 S. LaFountain  
 Phares, Mrs. R. W. . . . . 905 W. Mulberry  
 Rhorer, Mrs. H. M. . . . . 511 W. Sycamore  
 Rudicel, Mrs. M. W. . . . . 1700 S. Wash.  
 Schuler, Miss Lucy . . . . . 502 N. Main  
 Schwartz, Mrs. F. C. . . . . 1503 Kingston  
 Shenk, Mrs. E. M. . . . . 306 N. Webster  
 Sorenson, Mrs. Raymond . . . . . 1723 W. Walnut  
 Spangler, Mrs. J. S. . . . . 2126 S. Webster  
 Evans, Mrs. Robert . . . . . Russiaville  
 Tranter, Mrs. Frank . . . . . Sharpsville

**HUNTINGTON COUNTY****Huntington**

Brubaker, Mrs. Harold S. . . . . Flaxmill Rd.  
 Casey, Mrs. Stanley M. . . . . 408 E. Market  
 Clunie, Mrs. William A. . . . . 323 West Park Dr.  
 Cope, Mrs. Stanton . . . . . 1022 N. Jefferson  
 Erehart, Mrs. Mark G. . . . . 232 W. Market  
 Eviston, Mrs. J. Boyd . . . . . 1392 Poplar  
 Gray, Mrs. Paul M. . . . . 340 E. Market  
 Grayston, Mrs. Fred W. . . . . 708 N. Jefferson  
 Grayston, Mrs. Wallace S. . . . . 303 E. Market  
 James, Mrs. Thomas, Jr. . . . . 1044 Poplar  
 Johnston, Mrs. Robert G. . . . . 339 E. Market  
 Marks, Mrs. Howard H. . . . . 1433 Cherry  
 Mitman, Mrs. Floyd B. . . . . 1470 Poplar  
 Nie, Mrs. Grover M. . . . . 1518 Cherry  
 Omstead, Mrs. Trevalyn W. . . . . 1511 N. Jefferson  
 Ware, Mrs. J. Roger . . . . . 622 Henry

Woods, Mrs. Halden C. . . . . Markle  
 Galbreath, Mrs. Russell S. . . . . Rt. 2, South Whitley

**Warren**

Bennett, Mrs. J. B.  
 Black, Mrs. Claude S.  
 Bonifield, Mrs. Harold F.  
 Smith, Mrs. Lucian W.

**JENNINGS-JACKSON COUNTIES**

Gillespie, Mrs. G. R. . . . . Brownstown  
 Shields, Mrs. Jack . . . . . Brownstown  
 Adair, Mrs. W. K. . . . . 208 S. Armstrong, Crothersville  
 Bard, Mrs. F. B. . . . . 305 E. Howard, Crothersville  
 Cummings, Mrs. D. J. . . . . Ewing  
 Scharbrough, Mrs. Wm. . . . . Medora  
 Colli, Mrs. Louis J. . . . . 408 S. State, N. Vernon  
 Green, Mrs. John . . . . . S. Elm, N. Vernon

**JENNINGS-JACKSON  
COUNTIES**

(Continued)

Matthews, Mrs. D. W.  
147 W. Walnut, N. Vernon  
Thayer, Mrs. Benet  
Jennings St., N. Vernon

**Seymour**

Black, Mrs. J. M. . . . . Sunset Pkwy  
Day, Mrs. Durbin . . . . . 515 W. 6th  
Elsner, Mrs. L. W. . . . . 503 W. 6th  
Gillespie, Mrs. Charles E.  
602 N. Walnut  
Graessle, Mrs. H. P. 419 N. Walnut  
Kamman, Miss Martha 332 W. Oak  
Martin, Mrs. Guy. 1408 Ewing Rd.  
Miller, Mrs. Harold. 733 W. 7th  
Osterman, Mrs. L. H.  
901 Garden Ave.  
Ripley, Mrs. John W. 321 Bruce  
Shortridge, Mrs. W. H.  
313 Carter Blvd.  
Wiethoff, Mrs. C. A.  
327 Calvin Rd.

**JASPER-NEWTON  
COUNTIES**

Pippenger, Mrs. Wayne G. Brook  
Smith, Mrs. Hunter . . . . . Goodland  
Mathews, Mrs. W. C. . . . . Kentland  
Yegerlehner, Mrs. R. S. . . . . Kentland  
Mac Leod, Mrs. D. F. . . . . Morocco  
Williams, Mrs. Hugh . . . . . Morocco  
Schantz, Mrs. Richard. Remington  
Sink, Mrs. Frank . . . . . Remington

**Rensselaer**

Beaver, Mrs. E. R.  
English, Mrs. Harry E.  
Kresler, Mrs. L. E.  
O'Neill, Mrs. M. J.  
Schumaker, Mrs. Eugene

**JAY COUNTY**

Heller, Mrs. Norman C. . . . . Dunkirk

**Portland**

Badders, Mrs. Ara C. 709 W. North  
Cripe, Mrs. Wm. H. 507 W. High  
Engle, Mrs. John Max  
503 W. Walnut  
Fitzpatrick, Mrs. James S.  
420 N. Pleasant  
Hammond, Mrs. Stanley M.  
S. Meridian Street Rd.  
Keeling, Mrs. Forrest E.  
305 E. Walnut  
Moran, Mrs. Mark M.  
403 E. Walnut  
Morrison, Mrs. George G.  
North & Park Sts.  
Spahr, Mrs. Donald E. 615 W. Race  
Steffy, Mrs. Ralph. 321 E. Race

**JEFFERSON COUNTY****Madison**

Alcorn, Mrs. Merritt O.  
617 E. Main  
Beetem, Mrs. Luther F.  
411 N Broadway  
Childs, Mrs. Wallace Edward  
420 Elm

Jolly, Mrs. Lewis Everette  
J. P. A. Area  
Kemp, Mrs. Milburn W. 413 N. Elm  
May, Mrs. George Arthur . . . . . R.R. 5  
Petway, Mrs. Allen Paul  
411 W. 1st  
Rains, Mrs. Rinda  
King's Daughters Hospital  
Shuck, Mrs. Wm. A. . . . . R.R. 3  
Whitsitt, Mrs. Schuyler  
718 W. Main  
Zink, Mrs. Robert Otto. 426 Vine

**JOHNSON COUNTY****Edinburg**

Baker, Mrs. J. V.  
215 W. Main Cross  
Dettman, Mrs. John  
107 N. Franklin  
Michaels, Mrs. J. F. State Rd. 31

**Franklin**

Deppe, Mrs. Charles F.  
1215 Park Ave.  
Ferrara, Mrs. Joseph. 1000 E. King  
Jones, Mrs. Charles A. E. Adams  
Manuel, Mrs. Donald C.  
89 N. Walnut  
Murphy, Mrs. Harry E.  
150 N. Main  
Payne, Mrs. Carl F. 151 N. Main  
Portteus, Mrs. Walter L.  
N. Forsythe  
Province, Mrs. Oran A.  
99 N. Water  
Province, Mrs. Wm. D. . . . . R.R. 3  
Records, Mrs. Arthur W.  
216 E. Jefferson  
Wilson, Mrs. Russell. 351 E. King

**Greenwood**

Brown, Mrs. George E.  
Beech Park Dr.  
Craig, Mrs. J. A. . . . . E. Pearl  
Eaton, Mrs. Lyman D.  
Springdale Addition  
Machledt, Mrs. John H.  
243 S. Madison  
Sheek, Mrs. Kenneth I.  
165 N. Brewer  
Tiley, Mrs. George A.  
41 N. Madison  
Woodcock, Mrs. Charles W.  
240 S. Madison

**KNOX COUNTY**

Scudder, Mrs. J. A. . . . . Edwardsport  
Raper, Mrs. George. Freelandville

**Vincennes**

Anderson, Mrs. Richard M.  
Monroe City Rd.  
Arbogast, Mrs. Paul B.  
1420 Old Orchard Rd.  
Beckes, Mrs. Elsworth W.  
220 N. 5th  
Chattin, Mrs. Herbert O.  
729 Main  
Coffel, Mrs. Melvin H. . . . . 929 Perry  
Cullison, Mrs. Charles H.  
47 Cloverdale  
Curtner, Mrs. Myron L. 216 N. 6th  
Davis, Mrs. Howard B.  
1415 N. 11th  
Edwards, Mrs. Edward T., Jr.  
1232 N. 11th

Ewing, Mrs. Nathaniel D.  
Monroe City Rd.  
Fox, Mrs. Maurice S. . . . . 704 N. 7th  
Frigge, Mrs. Edward H. . . . . 609 Main  
Green, Mrs. Carl L.  
1414 Weed Lane  
Humphreys, Mrs. Joe S.  
1602 Weed Lane  
Keezer, Mrs. Wm. . . . . 715 Buntin  
McCormick, Mrs. Hubert D.  
518 N. 4th  
McDowell, Mrs. M. M.  
1322 Audubon Rd.  
McMahan, Mrs. V. C.  
Old Wheatland Rd.  
Moore, Mrs. Robert G.  
1309 Old Orchard Rd.  
Reilly, Mrs. James F.  
401 Buntin  
Richards, Mrs. D. H.  
904 Busseron  
Schulze, Mrs. Wm. . . . . 819 Buntin  
Shaffer, Mrs. Kenneth  
404 LaPlante Bldg.  
Small, Mrs. E. F. . . . . 526 Scott  
Smith, Mrs. Ralph O.  
Old Orchard Rd.  
Spencer, Mrs. Frederic. 311 N. 9th  
Sullenger, Mrs. A. A. . . . . 803 Perry  
Welch, Mrs. Norbert M.  
Monroe City Rd.  
Lutes, Mrs. D. L. . . . . Wheatland

**KOSCIUSKO COUNTY**

Urschel, Mrs. Dan L. . . . . Mentone  
Waltz, Mrs. Frank C. . . . . Mentone  
Schuldt, Mrs. T. S. . . . . Pierceton

**Warsaw**

Haymond, Mrs. G. M.  
532 E. Center  
Murphy, Mrs. Samuel C.  
216 S. High  
Richer, Mrs. Orville H.  
914 E. Main  
Roesch, Mrs. Ryland. . . . . N. Lake  
Schlemmer, Mrs. George H.  
528 N. Lake

**LAKE COUNTY**

Stasick, Mrs. Murray  
307-154th Place, Calumet City, Ill.

**Crown Point**

Becker, Mrs. P. H.  
Parramore Hospital  
Birdzell, Mrs. J. P.  
Ellendale Pkwy.  
Hasler, Mrs. N. . . . . Ellendale Pkwy.  
Horst, Mrs. W. N. . . . . 126 N. Court  
Klaus, Mrs. J. N. . . . . 667 S. Main  
Troutwine, Mrs. W. R. . . . . S. Main  
Carleton, Mrs. E. H.  
R.R. 1, Box 175, Dyer  
East Chicago  
Arnold, Mrs. M. F. . . . . 4239 Magoun  
Benchik, Mrs. Frank. 4712 Magoun  
Bonaventura, Mrs. Angelo P.  
1604 E. 142nd  
Boys, Mrs. Fay F.  
4143 Northcote  
Cotter, Mrs. Thomas F. . . . . 4221 Ivy  
Ernst, Mrs. H. C. . . . . 4219 Baring  
Fleischer, Mrs. J. C. . . . . 4135 Ivy



## LAKE COUNTY

## (East Chicago—Continued)

Grosso, Mrs. William G.  
3502 Grand Blvd.  
Gustaitis, Mrs. John W.  
4318 Parrish  
Johns, Mrs. David R. 1211 Beacon  
McGuire, Mrs. Desmond F.  
1910 142nd  
Niblick, Mrs. James S.  
4122 Parrish  
Petronella, Mrs. Sam J.  
4308 Baring  
Shapiro, Mrs. Joseph. 4216 Ivy  
Mather, Mrs. J. W.  
2367 Vigo, East Gary

## Gary

Almquist, Mrs. C. O. 550 Lincoln  
Behn, Mrs. Walter. 652 McKinley  
Bendler, Mrs. Carl H.  
225 Morningside  
Bills, Mrs. R. N. 534 Lincoln  
Brady, Mrs. Samuel J. 451 Garfield  
Brandman, Mrs. Harry. 629 Grant  
Carbone, Mrs. Joseph  
526 Johnson  
Chevigny, Mrs. J. J. 654 Johnson  
Cooper, Mrs. Leo K. 670 Hayes  
Davis, Mrs. Neal  
Box 928, Ogden Dunes  
Dierolf, Mrs. Edward J.  
630 Montgomery  
Elliott, Mrs. Ralph A. 1726 W. 6th  
English, Mrs. Hubert M. 575 Taft  
Goldberg, Mrs. Harold B.  
3643 Tyler  
Goldstone, Mrs. Adolph  
1430 W. 7th  
Goldstone, Mrs. Joseph  
600 Cleveland  
Goldstone, Mrs. Sidney R.  
566 Taft  
Gregoline, Mrs. A. F. 700 Arthur  
Harris, Mrs. Donald M.  
4813 Madison  
Jannasch, Mrs. M. Clifford  
2140 W. 2nd  
Kahan, Mrs. Harry L. 403 Johnson  
Kendrick, Mrs. Frank J.  
552 Johnson  
Kobrin, Mrs. Meyer W.  
2300 W. 6th  
Kopcha, Mrs. Joseph E. 715 Hayes  
Korn, Mrs. Jerome M. 3653 Polk  
Lebioda, Mrs. Henry S.  
3739 Adams  
Lewis, Mrs. George N.  
463 Taft Place  
Lorenty, Mrs. T. B.  
3654 Madison  
May, Mrs. R. Milton  
667 Van Buren  
Minczewski, Mrs. R. C. 361 Chase  
Molengraft, Mrs. C. J.  
544 Monroe  
Morris, Mrs. Hyman R.  
558 Taney Place  
Moswin, Mrs. Jack A. 477 Arthur  
Ornelas, Mrs. Joseph P.  
230 W. 36th  
Palmer, Mrs. Russell H.  
2006 W. 4th Place  
Parker, Mrs. H. C.  
Box 718, Beach Lane  
Parratt, Mrs. L. W.  
3526 Madison

Robinson, Mrs. Walter K.  
4024 E. 10th  
Roth, Mrs. L. 2801 W. 7th Place  
Rubin, Mrs. Simon S. 2131 W. 5th  
Sala, Mrs. Joseph J. 2333 W. 5th  
Sala, Mrs. Walter R. 2035 W. 8th  
Senese, Mrs. Thomas J.  
581 Johnson  
Shevick, Mrs. Alexander. 667 Taft  
Spellman, Mrs. F. W. 640 Illinois  
Stimson, Mrs. Harry R.  
4338 Jefferson  
Thomas, Mrs. G. L. 594 Taney  
Verplank, Mrs. G. L. R.R. 1  
Vye, Mrs. J. Preston  
3620 Madison  
Weiskopf, Mrs. Henry S.  
608 Roosevelt  
Wharton, Mrs. R. O. 703 Johnson  
Yocum, Mrs. Paul S. 578 Roosevelt  
Young, Mrs. G. M. 4580 Wash.  
Watts, Mrs. A. A. 620 Lincoln  
Wicks, Mrs. C. O. 560 Van Buren

## Griffith

Malmstone, Mrs. Francis A.  
114 E. Main  
Siekierski, Mrs. Joseph M.  
445 Broadway

## Hammond

Allegretti, Mrs. Michael L.  
6237 Forest  
Beconovich, Mrs. Robert. 839 169th  
Beilke, Mrs. C. A. 6806 Huron  
Brown, Mrs. Stanley Lee  
6550 Hohman  
Chidlaw, Mrs. B. W.  
29 Wildwood Rd.  
Cook, Mrs. George M. 6607 Forest  
Cotter, Mrs. Edward R.  
7225 Knickerbocker  
Eggers, Mrs. Henry W.  
6542 Hohman  
Elledge, Mrs. Ray. 6415 Forest  
Fischer, Mrs. Burnell  
7403 Van Buren  
Gevirtz, Mrs. Milton B.  
6528 Forest  
Hack, Mrs. Edmund C. 7147 Olcott  
Hickman, Mrs. A. Lee, Jr.  
614 165th  
Hopkins, Mrs. J. R. 22 Coolidge  
Husted, Mrs. Robert G.  
224 Fernwood  
Jones, Mrs. E. S. 50 Kenwood  
Kaplan, Mrs. Ben B. 2035 169th  
Komoroske, Mrs. John E.  
35 Highland  
Koransky, Mrs. David S.  
7028 Forest  
Kretsch, Mrs. R. W. 7214 Hohman  
Lazo, Mrs. Vincente R. 734 Sibley  
Marks, Mrs. Ora L. 7111 Olcott  
Marks, Mrs. Salvo P. 539 Cherry  
Matthews, Mrs. Charles B.  
6416 Forest  
Modjeski, Mrs. Raymond J.  
223 Locust  
Nakadate, Mrs. K. J.  
907 173rd Place  
Neal, Mrs. L. W. 7507 Olcott  
Nelson, Mrs. Richard B. 41 172nd  
Panares, Mrs. S. V. 4 172nd Place  
Peck, Mrs. Edward A.  
6422 Moraine  
Pilot, Mrs. Jean  
7137 Knickerbocker Pkwy.

Premuda, Mrs. Franklin F.  
6545 Alexander  
Remich, Mrs. Antone C.  
6412 Moraine  
Rendel, Mrs. Donald T. 18 172nd  
Rhind, Mrs. A. W. 7126 Forest  
Row, Mrs. P. Q. 6706 Hohman  
Rudolph, Mrs. F. G. 216 Lawndale  
Schlesinger, Mrs. J. 7251 Forest  
Shanklin, Mrs. E. M. 14 Ruth  
Stern, Mrs. S. Lewis. 226 Oakwood  
Stevens, Mrs. E. W. 6913 Monroe  
Thegze, Mrs. George. 7435 Olcott  
Tilka, Mrs. Edward C.  
1037 River Rd.

Markey, Mrs. Richard J.  
8740 Cottage Grove, Highland  
Sroka, Mrs. Stanley J.  
8608 Kennedy Ave., Highland  
Dupes, Mrs. L. E.  
727 Main, Hobart  
Potts, Mrs. William,  
3543 Ridge Rd., E., Lansing, Ill.  
Combs, Mrs. L. W. Lowell  
Mirro, Mrs. John A. Lowell  
Munster  
Arbeiter, Mrs. Herbert I.  
229 Belden Place  
Arrowsmith, Mrs. James L.  
8138 Forest  
Eggers, Mrs. Ernest L.  
8147 Meadow Lane  
Friedman, Mrs. I. E.  
11 Beverly Place  
Larrabee, Mrs. J. 8143 State Line  
Rosevear, Mrs. Henry J.  
230 Belden

## Whiting

Dainko, Mrs. Alfred D. 618 118th  
Jones, Mrs. C. M. 1925 Westpark  
Stecy, Mrs. Peter. 1543 Warwick

## LAPORTE COUNTY

Oak, Mrs. D. D., Jr. Hanna  
Oak, Mrs. D. D., Sr. LaCrosse

## LaPorte

Carter, Mrs. Fred. 402 E. Jefferson  
Farnsworth, Mrs. S. A. 117 Fox  
Jones, Mrs. J. C. 2102 Michigan  
Jones, Mrs. R. B. 1515 Indiana  
Kelsey, Mrs. Robert. 2107 Monroe  
Kepler, Mrs. Robert W. 1529 Mich.  
Larson, Mrs. G. O. 1006 Monroe  
Muhleman, Mrs. C. E. Greenacres  
Moosey, Mrs. Louis. 2007 Michigan  
Richter, Mrs. J. C. 1421 Indiana  
Scott, Mrs. J. S.  
508 Lake Shore Drive  
VonAshe, Mrs. Geo. 707 Weller

## Michigan City

Armstrong, Mrs. T. D.  
E. Coolspring  
Bankoff, Mrs. M. L. 1412 Wash.  
Bernoske, Mrs. Daniel. 731 Pine  
Cleveland, Mrs. B. 314 Fir  
Fargher, Mrs. F. M.  
Pottawattomie Park  
Gardner, Mrs. R. A. Long Beach  
Gilmore, Mrs. Russell. 815 Wash.  
Gilmore, Mrs. Robert. 216 W. 9th  
Jones, Mrs. King. 215 E. 2nd  
Kerrigan, Mrs. J. V.  
E. Coolspring

## LA PORTE COUNTY

## (Michigan City—Continued)

Kling, Mrs. Victor... Long Beach  
 Krieger, Mrs. G. M.... 701 Wash.  
 Kubik, Mrs. F. J.  
     Pottawattomie Park  
 Meyer, Mrs. Milo... Long Beach  
 Piazza, Mrs. L. F.... 2402 York  
 Plank, Mrs. C. R.... Long Beach  
 Robrock, Mrs. L. M.... 302 Dewey  
 Shortall, Mrs. James P.  
     2948 Mt. Claireway, Long Beach  
 Feerer, Mrs. Donald... 117 W. 7th  
 Kohrman, Mrs. B. M. 3011 Franklin  
 Kemp, Mrs. John..... 631 Pine

Weinstock, Mrs. A. Rolling Prairie  
 Benz, Mrs. O. F.... Wanatah  
 Townsend, Mrs. Ralph  
     Beatty Mem. Hospital, Westville

## MADISON COUNTY

## Anderson

Aagesen, Mrs. Walter J.  
     Forest Hills  
 Armington, Mrs. Robert L.  
     Kilbuck Rd.  
 Armington, Mrs. John C.  
     206 E. 14th  
 Ayres, Mrs. Kenneth D.  
     2210 Meridian  
 Austin, Mrs. Maynard A.  
     238 W. 12th  
 Benoit, Mrs. Merrill  
     Maple Road, Edgewood  
 Bixler, Mrs. Donald P.  
     1008 E. 38th  
 Blassaras, Mrs. Crist A.  
     Forest Hills  
 Brown, Mrs. James M. 727 E. 31st  
 Buckles, Mrs. David L.  
     44 Knoll Rd., Edgewood  
 Conrad, Mrs. Ernest M.  
     2124 Meridian  
 Dixon, Mrs. Rex W... 936 W. 8th  
 Donaldson, Mrs. Frank C.  
     1010 E. 38th  
 Drake, Mrs. John C.  
     Madison Heights  
 Ellis, Mrs. Seth W... Forest Hills  
 Elsten, Mrs. Wayne A.  
     Forest Manor  
 Erehart, Mrs. Archie D.  
     1221 Irving Way  
 Fischer, Mrs. Warren E.  
     Grandview Terrace  
 Gante, Mrs. Henry W.  
     2005 Nichol  
 Guthrie, Mrs. Francis C.  
     2205 Nichol  
 Hart, Mrs. Wm. D... 1026 W. 8th  
 Hensler, Mrs. Benton M.  
     717 Winding Way, Edgewood  
 Jones, Mrs. Albert T. 1930 W. 12th  
 Kelly, Mrs. Wendell C.  
     Colony Rd., Edgewood  
 King, Mrs. Bernard A., 231 W. 8th  
 King, Mrs. Joseph W.  
     260 Davis Drive, Edgewood  
 Larmore, Mrs. Joseph L.  
     1301 Winding Way, Edgewood  
 Litzenberger, Mrs. Sam W.  
     Forest Hills  
 Long, Mrs. Paul L. Forest Hills  
 Metcalf, Mrs. George B. 830 W. 8th  
 Morris, Mrs. Robert A. 233 W. 8th

Neale, Mrs. Alfred E.  
     630 Madison  
 Nesbitt, Mrs. Leonard L.  
     R.R. 6, Box 10, 8th Street Rd.  
 Patterson, Mrs. William K.  
     2747 Nichol  
 Polhemus, Mrs. Warren C.  
     1800 W. 11th  
 Rosenbaum, Mrs. Lloyd E.  
     Forest Hills  
 Ross, Mrs. Guy E.  
     Madison Heights  
 Rozelle, Mrs. Clarence V.  
     Forest Hills  
 Stamper, Mrs. Joseph  
     R.R. 7, Box 47  
 Swan, Mrs. Richard C. Forest Hills  
 Webb, Mrs. Harry D.  
     Central Way, Edgewood  
 Wilder, Mrs. Gordon B. 338 W. 8th  
 Williams, Mrs. Robert H.  
     1907 W. 10th  
 Wilkinson, Mrs. Roger L.  
     1525 Winding Way, Edgewood  
 Wishard, Mrs. Fred B. 505 W. 9th  
 York, Mrs. Arthur F. State Rd. 32  
 Zierer, Mrs. Reuben O.  
     Woodlawn Heights

Drake, Mrs. Marion C.... Elwood  
 Scea, Mrs. Wallace A.  
     1402 S. F St., Elwood  
 Bishop, Mrs. Harry A. Frankton  
 Williams, Mrs. Robert D.  
     Markleville  
 McLaughlin, Mrs. Calvin P.  
     Pendleton  
 Williams, Mrs. Francis M.  
     Pendleton

## MARION COUNTY

Ramage, Mrs. Walter F.  
     244 S. 1st, Beech Grove  
     Indianapolis  
     A  
 Adkins, Mrs. Harold C.  
     250 W. Hampton Drive  
 Albertson, Mrs. Frank P.  
     5031 Rockville Rd.  
 Aldrich, Mrs. Harry D. 3039 Park  
 Alvis, Mrs. Edmund O.  
     8000 Morningside Dr.  
 Arbuckle, Mrs. Russell L.  
     3716 Watson Rd.  
 Arbuckle, Mrs. William E.  
     1759 W. Morris

## B

Bachmann, Mrs. Arnold J.  
     3239 Winfield  
 Bakemeier, Mrs. Otto H.  
     5535 E. St. Clair  
 Ball, Mrs. Joseph E. 823 N. Lesley  
 Bartley, Mrs. Max D. 107 E. 48th  
 Batman, Mrs. Gordon W.  
     6906 N. Delaware  
 Bean, Mrs. Joseph S.  
     1425 N. Berwick  
 Beasley, Mrs. Thos. J.  
     112 Berkley Rd.  
 Beaver, Mrs. Howard W.  
     R.R. 6, Box 158  
 Berman, Mrs. Jacob K.  
     1105 W. Kessler Blvd.  
 Bibler, Mrs. Lester D.  
     3821 Guilford

Blatt, Mrs. A. Ebner  
     5330 N. Illinois  
 Bowman, Mrs. George W.  
     5634 Carrollton  
 Boyer, Mrs. Floyd A.  
     136 S. Wittfield  
 Brady, Mrs. Thomas A.  
     440 Berkley Rd.  
 Brayton, Mrs. John R.  
     3128 E. Fall Creek Blvd.  
 Brodie, Mrs. Donald W.  
     R.R. 12, Box 241 M  
 Brown, Mrs. Edward A.  
     5420 Central  
 Brown, Mrs. Wendell,  
     3750 N. Gale  
 Browning, Mrs. William M.  
     2844 Questend Drive  
 Brubaker, Mrs. E. H. 624 E. 23rd  
 Bunde, Mrs. Earl A. 952 Downey  
 Burghard, Mrs. Rolla 2171 E. 67th

## C

Cahn, Mrs. Hugo M. 3038 Park  
 Call, Mrs. Herbert F. 710 E. 57th  
 Campbell, Mrs. John A.  
     5201 Grandview  
 Carlson, Mrs. Charles E.  
     6130 N. Carvel  
 Carson, Mrs. E. Wayne,  
     7177 N. Meridian  
 Carter, Mrs. Larue D.  
     4280 N. Meridian  
 Carter, Mrs. Oren E.  
     5461 Kenwood  
 Clark, Mrs. Lawson J.  
     2425 E. Kessler Blvd.  
 Cohn, Mrs. Frank 1120 S. View Dr.  
 Conley, Mrs. Joseph L.  
     1617 E. Ohio  
 Conway, Mrs. Glenn,  
     2235 E. Garfield Dr.  
 Cornacchione, Mrs. Matthew  
     5703 Broadway Terrace  
 Cortese, Mrs. James V.  
     124 W. Troy  
 Cortese, Mrs. Thomas A.  
     3240 Brill Rd.  
 Cox, Mrs. Clifford E.  
     R.R. 16, Box 593  
 Craven, Mrs. Howard T.  
     730 E. 52nd  
 Cure, Mrs. Charles W.  
     5215 Hinsley  
 Cuthbert, Mrs. Marvin  
     5611 N. Delaware

## D

Davidson, Mrs. N. Cort  
     6901 Washington Blvd.  
 Davis, Mrs. Sam J. 5114 Park  
 Day, Mrs. Clark... 29 W. 42nd  
 Dearmin, Mrs. Robert M.  
     5147 N. Delaware  
 DeArmond, Mrs. Albert M.  
     5401 N. Delaware  
 Deeever, Mrs. John W.  
     4160 Madison  
 DeWees, Mrs. Dwight L.  
     302 N. Bradley  
 Denny, Mrs. James W.  
     84 N. Audubon Rd.  
 Donato, Mrs. Albert M.  
     4225 South East  
 Donner, Mrs. Paul... 1832 E. 10th  
 Dorman, Mrs. W. Leland  
     R.R. 9, Box 157  
 Drake, Mrs. William L., Jr.  
     6110 Carvel



### MARION COUNTY (Indianapolis—Continued)

Dugan, Mrs. William M.  
5747 Rolling Ridge Rd.  
Dunbar, Mrs. Colin V.  
3625 Watson Rd.  
Dunning, Mrs. Lehman M.  
5435 N. Pennsylvania  
Dyar, Mrs. Edwin W.  
5910 Washington Blvd.

#### E

Eastman, Mrs. Joseph R., Jr.  
8217 Spring Mill Rd.  
Eastman, Mrs. Joseph R.  
8160 N. Meridian  
Eaton, Mrs. Edwin R.  
5750 Allisonville Rd.  
Ebert, Mrs. J. Wayne  
1601 Homecroft Dr.  
Eberwein, Mrs. John H.  
414 E. Fall Creek Pkwy.  
Egbert, Mrs. Herbert L.  
3210 Washington Blvd.  
Eicher, Mrs. Palmer  
4902 Park  
Eldridge, Mrs. Gail E.  
5746 Central

Ellis, Mrs. Bert E.  
R.R. 2, Box 439H  
Emhardt, Mrs. John T.  
3305 Brill Rd.  
Emhardt, Mrs. John W.  
5424 Washington Blvd.  
Ensminger, Mrs. Leonard A.  
1321 N. Meridian  
Ernst, Mrs. Clifford E.  
3206 N. Sharon  
Evans, Mrs. Paul V.  
5725 Indianola  
Everly, Mrs. Ralph V.  
1105 E. 58th

#### F

Fausset, Mrs. C. Basil  
5236 Graceland  
Fisch, Mrs. Charles  
5857 Kingsley Dr.  
Flanigan, Mrs. Meridith B.  
2920 W. 33rd  
Flora, Mrs. Joseph O.  
5604 Rockville Rd.  
Folkening, Mrs. Norval C.  
3501 Camden  
Foreman, Mrs. Harry L.  
3335 Washington Blvd.  
Fouts, Mrs. Paul J.  
8393 N. Illinois  
Fromhold, Mrs. Willis A.  
5514 Manker  
Fry, Mrs. Robert D.  
5717 Broadway

#### G

Gabe, Mrs. William E.  
502 W. Hampton Dr.  
Gambill, Mrs. Wm. Dudley  
R.R. 17, Box 66  
Garber, Mrs. J. Neill, 1101 E. 57th  
Garceau, Mrs. George J.  
4334 N. Pennsylvania  
Gardiner, Mrs. Sprague H.  
46 W. 52nd  
Gardner, Mrs. Buckman  
315 W. Hampton Dr.  
Garfield, Mrs. Martin  
3704 Watson Rd.  
Garner, Mrs. W. Stanley  
3785 E. 62nd  
Garrett, Mrs. John D.  
R.R. 3, Box 789

Garrett, Mrs. Robert A.  
5242 Boulevard Place  
Gaskill, Mrs. Herbert S.  
4528 College  
Gastineau, Mrs. Frank M.  
5344 N. Pennsylvania  
Geider, Mrs. Roy A.  
5816 Pleasant Run Pkwy.  
George, Mrs. Charles, 1121 E. 80th  
Gick, Mrs. Herman H.  
451 Eastern  
Gifford, Mrs. Fred E.  
5125 N. Meridian  
Gillespie, Mrs. Charles F.  
2615 E. 35th  
Goldman, Mrs. Samuel  
5632 Rosslyn  
Gosman, Mrs. James H.  
340 E. Maple Rd.  
Greist, Mrs. John H., 5032 Park  
Griffith, Mrs. Richard S.  
1676 Winton  
Griffith, Mrs. Ross E.  
4452 Washington Blvd.  
Grisell, Mrs. Ted L.  
5411 Broadway  
Gustafson, Mrs. Gerald W.  
5768 N. Pennsylvania

#### H

Habich, Mrs. Carl, 4335 Broadway  
Hadley, Mrs. David  
3132 N. New Jersey  
Haggard, Mrs. Edmund B.  
3481 Birchwood  
Hahn, Mrs. E. Vernon  
R.R. 2, Box 376  
Hall, Mrs. Frank  
6969 College  
Hall, Mrs. Jack R., 3542 Kenwood  
Hamer, Mrs. Homer G.  
4454 N. Pennsylvania  
Hampshire, Mrs. Donald  
4378 Central  
Hanley, Mrs. Edward J.  
5653 Winthrop  
Hanna, Mrs. Thomas A.  
5090 W. 15th  
Hansell, Mrs. Robert M.  
3525 N. Gladstone  
Harcourt, Mrs. Allan K.  
4915 N. Illinois  
Harding, Mrs. M. Richard  
2830 W. 33rd  
Harding, Mrs. Myron S.  
46 W. 46th  
Harold, Mrs. Albert H.  
7510 Allisonville Rd.  
Harold, Mrs. Norris E.  
3545 N. Denny  
Haslinger, Mrs. Clarence J.  
5236 Boulevard Place  
Hawk, Mrs. James H.  
4485 N. Pennsylvania  
Haymond, Mrs. Joseph L.  
551 E. 36th  
Hays, Mrs. Everett L.  
2607 Manker  
Helmer, Mrs. O. M.  
5015 N. Illinois  
Hendricks, Mrs. John W.  
124 W. 64th  
Henry, Mrs. Russell S., 710 E. 58th  
Hepburn, Mrs. Charles K.  
R.R. 14, Box 187L  
Hetherington, Mrs. A. M.  
5224 Pleasant Run Blvd.  
Hetherington, Mrs. John  
445 E. 71st

Heubi, Mrs. John E.  
5061 N. Illinois  
Hickman, Mrs. Walter F.  
3107 N. Meridian, Apt. E  
Holman, Mrs. Jerome E., Jr.  
5359 Guilford  
Holman, Mrs. Jerome E., Sr.  
R.R. 13, Box 73  
Hood, Mrs. Ainslee A.  
1444 W. 25th  
Horwitz, Mrs. Thomas  
2158 Admiral  
Howell, Mrs. Joseph D.  
3431 Winthrop  
Howell, Mrs. Robert D.  
3641 N. Pennsylvania  
Hudson, Mrs. Foster J.  
525 W. Hampton Dr.  
Hughes, Mrs. James E.  
2534 Broadway  
Hughes, Mrs. William F., Sr.  
4025 N. Meridian  
I-J  
Iske, Mrs. Paul G., 5244 N. Penn.  
Irwin, Mrs. Glenn W., Jr.  
5022 Graceland  
Jaeger, Mrs. Alfred S.  
2935 Washington Blvd.  
Jaquith, Mrs. Orville S.  
261 Blue Ridge Rd.  
Jay, Mrs. Arthur N., 815 W. 64th  
Jennings, Mrs. Frank  
Sunnyside Sanitorium  
Jewett, Mrs. Joe H., 4907 Rosslyn  
Jinks, Mrs. Clifford H.  
5740 Carrollton  
Johnson, Mrs. Thomas W.  
5735 Washington Blvd.  
Jones, Mrs. David E.  
646 Berkley Rd.  
Joseph, Mrs. Rex M.  
R.R. 6, Box 524MM

#### K

Kammen, Mrs. Leo  
257 W. 46th  
Katterjohn, Mrs. James  
102 E. 50th  
Kauffman, Mrs. Nelson N.  
5970 Central  
Keenan, Mrs. Reid L.  
3702 N. Delaware  
Kelly, Mrs. Don E., 4927 Kenwood  
Kelly, Mrs. Walter F.  
6845 E. Pleasant Run Pkwy.  
Kennedy, Mrs. Hunter  
757 N. Bolton  
Kerr, Mrs. Harry R.  
5774 Washington Blvd.  
Kime, Mrs. Edwin N.  
239 Buckingham Dr.  
Kingsbury, Mrs. John K.  
5776 E. Michigan  
Kirklin, Mrs. Oren L.  
8005 Englewood Rd.  
Kirtley, Mrs. Wm. R., 730 E. 73rd  
Kiser, Mrs. Edgar F., 5610 Central  
Kitterman, Mrs. Harry E.  
5108 Graceland  
Klain, Mrs. Benjamin V.  
5775 Central  
Knowles, Mrs. Charles Y.  
1121 N. Downey  
Kohlstaedt, Mrs. Kenneth G.  
R.R. 14, Box 253  
Koons, Mrs. Karl M., 5767 N. Penn.  
Kornafel, Mrs. L. H., 6201 College  
Kraft, Mrs. Bennett  
7025 Washington Blvd.

### MARION COUNTY (Indianapolis—Continued)

Kuntz, Mrs. Herman W.  
823 Weghorst  
Kurtz, Mrs. Philip L.  
6841 Willow Rd.  
Kwitney, Mrs. I. J.  
5774 Broadway Terrace

#### L

LaDine, Mrs. Clarence B.  
4221 E. 35th  
Lamb, Mrs. Emmett B.  
1180 Golden Hill Dr.  
Lamb, Mrs. Russell W.  
4636 N. Capitol  
Lamber, Mrs. Chet K.  
1501 E. Maple Rd., Apt. 19  
Lawler, Mrs. George F.  
5601 E. St. Clair  
Leasure, Mrs. J. Kent  
3115 N. Meridian  
Leff, Mrs. Abe H. . . . 46 W. 52nd  
Levi, Mrs. Leon  
402 W. Hampton Dr.  
Lewis, Mrs. Robert J.  
3742 N. Denny  
Lichtenberg, Mrs. Melvin  
4021 N. New Jersey  
Link, Mrs. Goethe  
2609 Putters Lane  
Lochry, Mrs. Ralph L.  
6150 Crows Nest Dr.  
Loomis, Mrs. Norman S.  
5230 Kenwood  
Lord, Mrs. Glenn C.  
4455 Washington Blvd.  
Love, Mrs. George N.  
1644 N. Delaware  
Ludwig, Mrs. Oscar D.  
5433 Madison  
Lybrook, Mrs. William B.  
R.R. 13, Box 72M

#### M

McBride, Mrs. James S.  
7048 Warwick Rd.  
McCown, Mrs. Percy E.  
5008 N. Meridian  
McDavitt, Mrs. Daniel R.  
5470 Guilford  
McGrath, Mrs. Michael F.  
6183 Washington Blvd.  
McGuff, Mrs. Paul . . . 3545 College  
McIntire, Mrs. Clarence R.  
1726 N. Meridian  
McQuiston, Mrs. Ralph J.  
R. R. 15, Box 385  
McTurnan, Mrs. Robert W.  
5957 Kingsley Dr.  
MacGregor, Mrs. Donald E.  
6080 N. Michigan Rd.  
Mackey, Mrs. John E. . . 629 E. 32nd  
Madtson, Mrs. Ricks . . 5238 College  
Magennis, Mrs. Herbert L.  
3010 E. 38th  
Manion, Mrs. Marlow W.  
5132 N. New Jersey  
Mann, Mrs. Mortimer . . 28 E. 55th  
Manning, Mrs. Joseph C.  
3121 Sharon  
Manning, Mrs. K. Randolph  
5527 Broadway  
Marks, Mrs. Maurice S.  
4440 Marcey Lane, No. 148  
Marshall, Mrs. Albert L. Jr.  
3465 Carrollton

Marshall, Mrs. Cavins R.  
6120 N. Michigan Rd.  
Martin, Mrs. Loren H.  
5338 Washington Blvd.  
Martz, Mrs. Carl D.  
4571 Fall Creek Blvd., S. Dr.  
Masters, Mrs. John M. . . 34 E. 46th  
Matthew, Mrs. W. Burleigh  
3462 E. Fall Creek Blvd.  
Matthew, Mrs. William  
943 N. Franklin Rd.  
Megenhardt, Mrs. Dennis  
3038 E. Fall Creek Blvd.  
Mericle, Mrs. Earl W.  
4480 N. Meridian  
Merrell, Mrs. Paul  
270 Buckingham Dr.  
Mertz, Mrs. Henry O.  
721 Clarendon Pl.  
Micheli, Mrs. Arthur J.  
3453 N. Pennsylvania, Apt. 1  
Miller, Mrs. Raleigh S.  
6140 College

Millikan, Mrs. William J.  
2620 E. 59th  
Mitchell, Mrs. Earl H.  
2263 E. Riverside Dr.  
Moenning, Mrs. Walter P.  
7030 N. Pennsylvania  
Molt, Mrs. William F.  
2315 N. Talbot  
Montgomery, Mrs. William F.  
4546 Park  
Moore, Mrs. Harold T. . . 3220 Sharon  
Moore, Mrs. Robert M.  
5617 N. Meridian  
Morchan, Mrs. Samuel  
3116 E. 39th  
Morrison, Mrs. Lewis E.  
3460 Winthrop  
Morton, Mrs. Walter P.  
3434 E. Fall Creek Blvd., N. Dr.  
Muller, Mrs. Paul F. . . 4329 Park  
Myers, Mrs. Roy V.  
R. R. 13, Box 75

#### N

Nafe, Mrs. Cleon 5060 N. Meridian  
Nay, Mrs. Richard M.  
5257 Hinesley  
Need, Mrs. Lewis T. 3627 Bluff Rd.  
Nester, Miss Lena Laura  
2832 N. Capitol  
Nie, Mrs. Louis W. . . 4305 Central  
Noble, Mrs. Thomas B. J.  
4360 N. Pennsylvania  
Noe, Mrs. William R.  
5167 Atherton, S. Dr.  
Nolting, Mrs. Henry F.  
155 W. Hampton Dr.  
Norman, Mrs. William H.  
6416 Dean Rd.  
Nourse, Mrs. Myron 5251 Primrose  
Nugent, Mrs. Edwin J.  
2266 Wyndale Rd.

#### O

Ochsner, Mrs. Harold C.  
450 E. 45th  
Olvey, Mrs. Ottis N.  
5533 Broadway  
Otten, Mrs. Claude F. 4456 Central  
Ottinger, Mrs. Ross C.  
5720 Sunset Lane  
Owen, Mrs. John E. 4429 N. Illinois  
Owens, Mrs. Tracy  
2823 N. Meridian

#### P

Pandolfo, Mrs. Harry  
529 Markwood  
Patton, Mrs. Martin T.  
3060 N. Meridian, Apt. 504  
Paulissen, Mrs. George T.  
741 Markwood  
Paynter, Mrs. Morris B.  
Roberts Road  
Pearson, Mrs. Lyman R.  
Marott Hotel  
Peck, Mrs. Franklin B.  
5826 Winthrop  
Pennington, Mrs. Walter E.  
4420 N. Meridian  
Permer, Mrs. Erwin  
3018 N. Delaware  
Peters, Mrs. Robert J. D.  
3203 E. Michigan  
Pickett, Mrs. Robert . . 129 W. 41st  
Pollack, Mrs. Lewis . . 5658 Guilford  
Pryor, Mrs. Richard  
6134 Carrollton

#### R

Raber, Mrs. Robert 6036 Haverford  
Rader, Mrs. George S. 3778 E. 62nd  
Ramsey, Mrs. Frank B.  
1401 W. 52nd  
Reed, Mrs. Phillip B.  
4131 N. Meridian  
Rees, Mrs. Russell C.  
926 Ellenberger Pkwy., W. Dr.  
Reid, Mrs. Charles A.  
6512 Madison  
Rice, Mrs. Raymond M.  
5365 N. New Jersey  
Richardson, Mrs. Thad T.  
808 Whittier Pl.  
Ricketts, Mrs. Joseph W.  
5349 Kenwood  
Rigg, Mrs. John F.  
5115 N. Meridian  
Ritchey, Mrs. James O. 43 W. 43rd  
Robb, Mrs. John A. 5254 Broadway  
Rogers, Mrs. Donald L.  
2221 E. 39th

Roller, Mrs. Charles W.  
2301 Garfield Dr.  
Romberger, Mrs. Floyd T. Jr.  
370 W. 52nd  
Rosenak, Mrs. Bernard D.  
325 E. 45th  
Ross, Mrs. Alexander T.  
1105 W. Kessler Blvd.  
Row, Mrs. D. Hamilton  
5214 Grandview Dr.  
Ruddell, Mrs. Karl R.  
2626 N. Meridian  
Ruddell, Mrs. Keith  
1321 N. Meridian  
Rudolph, Mrs. Stephen J.  
3421 Kinnear  
Rupel, Mrs. Ernest  
701 Kessler Blvd., W. Dr.  
Rust, Mrs. Byron K.  
8120 Sycamore Rd.  
Ryan, Mrs. Glen V.  
3168 E. Fall Creek Pkwy., N. Dr.

#### S

Sage, Mrs. Russell A.  
R. R. 14, Box 221  
Salb, Mrs. Max C.  
1116 N. Pennsylvania  
Sanders, Mrs. Harry M.  
3443 N. DeQuincy  
Schechter, Mrs. John  
4966 Kingsley Dr.



**MARION COUNTY****(Indianapolis—Continued)**

Schneider, Mrs. Carl J.  
340 N. Kenyon  
Schuchman, Mrs. Gabriel  
5944 Central  
Schuster, Mrs. Dwight  
5042 N. Capitol  
Scott, Mrs. George E.  
3340 N. Meridian  
Sedam, Mrs. Herbert L.  
6931 Central  
Sexson, Mrs. Hiram T. 401 W. 46th  
Shafer, Mrs. Marion R.  
6290 Allisonville Rd.  
Sheehan, Mrs. Francis G.  
950 Graham  
Shugart, Mrs. Joseph A.  
2620 E. 37th  
Shumacker, Mrs. H. B. Jr.  
4330 N. Central  
Sicks, Mrs. Okla  
5609 N. Pennsylvania  
Sidebottom, Mrs. Earl W.  
2820 W. 29th  
Siekerman, Mrs. C. W.  
1604 Loretta  
Sigmond, Mrs. Harvey W.  
3245 N. Pennsylvania  
Sims, Mrs. J. Lawrence  
3723 N. Gale  
Sluss, Mrs. David  
3657 Washington Blvd.  
Smith, Mrs. Lester A.  
126 Berkley Rd.  
Smith, Mrs. Roy Lee  
R. R. 6, Box 473  
Solomon, Mrs. R. A.  
5330 N. Pennsylvania  
Sovine, Mrs. J. W. 5311 N. Illinois  
Spahr, Mrs. John F. Jr.  
3845 N. Meridian  
Sparks, Mrs. Alan L. 4310 Central  
Sputh, Mrs. C. B. Jr.  
5671 Rolling Ridge Rd.  
Sputh, Mrs. Carl B. Sr.  
7860 Barlum Dr.  
Stadler, Mrs. Harold E.  
6244 Washington Blvd.  
Stanley, Mrs. John  
3146 Washington Blvd.  
Stayton, Mrs. Chester A. Jr.  
5260 Cornelius  
Stayton, Mrs. Chester A. Sr.  
6925 N. Delaware  
Stephens, Mrs. Donald E.  
5555 Broadway  
Sterne, Mrs. S. Gloria  
Spink Arms Hotel, No. 317  
Stevens, Mrs. Sydney L.  
3430 N. Temple  
Stone, Mrs. A. T. 5727 Broadway  
Storey, Mrs. D. Edmund  
1320 N. Delaware  
Stout, Mrs. F. Eugene  
3225 Medford  
Stroup, Mrs. Tyler J. 5758 College  
Stucky, Mrs. Elsworth K.  
3602 Watson Rd.  
Stygall, Mrs. James H.  
4311 N. Meridian  
Sudranski, Mrs. Herbert F.  
3614 Guilford  
Sutton, Mrs. William E.  
5670 Guilford  
Swan, Mrs. John R. 320 Arden Dr.

Symmes, Mrs. Alfred T.  
717 W. 44th  
Szynal, Mrs. John S. 1841 Warman  
T  
Talbot, Mrs. Dan E.  
6470 N. Michigan Rd.  
Tanner, Mrs. Henry S.  
5144 N. Delaware  
Taylor, Mrs. Clifford  
5938 Crittenden  
Taylor, Mrs. Frederick W.  
40 E. 43rd  
Teague, Mrs. Frank W.  
8000 Sycamore Rd.  
Tether, Mrs. J. Edward  
2206 Lafayette Rd.  
Tharp, Mrs. Harold R.  
5302 E. St. Clair  
Tharpe, Mrs. Ray . . . Marott Hotel  
Thatcher, Mrs. Hugh K. Jr.  
745 W. 44th  
Thomas, Mrs. Lowell I.  
28 W. Hampton Dr.  
Thomas, Mrs. Morris E.  
5207 N. New Jersey  
Thompson, Mrs. Charles F.  
6038 N. Olney  
Thompson, Mrs. John V.  
7899 Ridge Rd.  
Thornburg, Mrs. K. E.  
4702 Washington Blvd.  
Thurston, Mrs. A. L. 421 E. 41st  
Tinney, Mrs. William E.  
3902 Carrollton  
Tinsley, Mrs. Walter B.  
3314 Carrollton  
Torrella, Mrs. Jose A. 5721 W. 18th  
Trusler, Mrs. Harold M.  
6150 N. Pennsylvania  
Tuchman, Mrs. Joseph H.  
1154 Hawk Lane  
Tucker, Mrs. Robert L.  
5075 Norwaldo

**V**

Vandivier, Mrs. Robert M.  
4738 Boulevard Pl.  
VanMeter, Mrs. E. Powell  
1925 N. Emerson  
VanOsdol, Mrs. Harry A.  
43 Hampton Drive  
VanTassel, Mrs. Chas. J. Jr.  
521 E. 60th  
Voyles, Mrs. Charles F.  
4150 N. Meridian

**W**

Waldo, Mrs. J. Thayer  
8383 N. Illinois  
Walker, Mrs. Frank C.  
5563 N. Pennsylvania  
Walther, Mrs. Joseph E.  
4266 N. Pennsylvania  
Warvel, Mrs. John H.  
4360 Kessler Blvd., N. Dr.  
West, Mrs. Joseph L.  
5261 Woodside Dr.  
Westfall, Mrs. B. Kemper Jr.  
6601 College  
Westfall, Mrs. John B. 32 E. 46th  
White, Mrs. Donald J.  
5430 N. Delaware  
White, Mrs. John B.  
3942 N. Adams  
Whitlock, Mrs. Francis C.  
901 N. Leland  
Wilkens, Mrs. Irvin W.  
4816 Pleasant Run Pkwy.

Williams, Mrs. Howard S.  
3908 Guilford  
Wilmore, Mrs. Ralph C.  
6015 Evanston  
Winters, Mrs. Matthew  
4044 Carrollton  
Wise, Mrs. William  
4934 N. Pennsylvania  
Wishard, Mrs. William N. Jr.  
4150 N. Illinois  
Wolfram, Mrs. Don J.  
5872 Broadway  
Worley, Mrs. J. P.  
5295 E. Pleasant Run Pkwy.,  
S. Dr.  
Wright, Mrs. J. William Jr.  
2115 Wilshire Rd.  
Wytttenbach, Mrs. John E.  
5509 Kenwood

**Y-Z**

Young, Mrs. James W.  
5815 Primrose  
Young, Mrs. John M.  
4525 Marcy Lane  
Young, Mrs. Woodson C.  
3215 Medford  
Zell, Mrs. Evertson H.  
4624 Norwaldo  
Stephens, Mrs. K. H. . . . Lawrence  
Miller, Mrs. Ray D.  
290 E. Washington, Martinsville  
New Augusta  
Asher, Mrs. Ernest O. . . . Box 4  
Asher, Mrs. James W.  
Brown, Mrs. David E. . . . R. R. 1  
Brown, Mrs. DeWitt Jr.  
R. R. 1, Box 2681

Burkhardt, Mrs. Boyd  
328 N. West, Tipton  
Jones, Mrs. George L. Wanamaker  
Bailey, Mrs. Lawrence S.  
110 S. Second, Zionsville

**MARSHALL COUNTY****Bremen**

Bowen, Mrs. Otis  
Burkett, Mrs. Cecil

**Culver**

Mackey, Mrs. C. G.  
Witham, Mrs. Robert L.

**Plymouth**

Klingler, Mrs. M. O.  
Kubley, Mrs. James  
Pomeroy, Mrs. Rex  
Robertson, Mrs. James  
Vore, Mrs. L. W.

**MIAMI COUNTY**

Shrock, Mrs. E. E. . . . . Amboy  
Line, Mrs. Homer . . . . . Chili  
Frybarger, Mrs. S. S. . . . Converse

**Macy**

Sennett, Mrs. W. K.  
Waite, Miss Carrie  
Waite, Miss Margaret

Rendel, Mrs. C. F. . . . . Mexico  
Rendel, Mrs. H. E. . . . . Mexico

MIAMI COUNTY

(Continued)

Peru

Baldwin, Mrs. C. A. 17½ S. Huntington  
 Barnett, Helen. 65 N. Miami  
 Berkebile, Mrs. John. 15 W. 6th  
 Carl, Mrs. Clara. 128 W. 3rd  
 Eikenberry, Mrs. B. F. 28 W. 6th  
 Johnson, Mrs. Owen B. 181 E. 6th  
 Lynn, Mrs. F. M. 258 W. Main  
 Malouf, Mrs. S. D. 359 W. 3rd  
 Wagner, Mrs. M. L. R. R. 4  
 Wildman, Mrs. R. E. R. R. 2  
 Yarling, Mrs. Francis. 117 E. 5th

MONTGOMERY COUNTY

Crawfordsville

Alexander, Mrs. Stephen J. 202 West  
 Ball, Mrs. T. Z. 401 S. Washington  
 Burks, Mrs. Jess E. 411 S. Walnut  
 Cooksey, Mrs. Thomas L. 206 Marshall  
 Cornell, Mrs. Robert A. 1000 S. Washington  
 Daugherty, Mrs. Fred N. 415 W. Main  
 Griffith, Mrs. James. 218 S. Green  
 Haller, Mrs. Thomas C. 508 W. Main  
 Humphreys, Mrs. John W. 206 Woodlawn  
 Kinnaman, Mrs. Howard A. R. R. 6  
 Kirtley, Mrs. James M. 201 S. Grant  
 Lingeman, Mrs. Byron J. 203 Wallace  
 Mount, Mrs. William M. 1417 W. Main  
 Pierson, Mrs. Robert H. 305 E. Main  
 Peacock, Mrs. Norman F. 107 Vernon Court  
 Sharp, Mrs. John L. 1403 E. Main  
 Wallace, Mrs. Hawthorne C. 107 W. Jefferson  
 Otten, Mrs. Ralph R. Darlington  
 Priebe, Mrs. Fred. Hillsboro  
 Smith, Mrs. Byron J. Kingman  
 Ladoga  
 Blix, Mrs. Fred  
 Denny, Mrs. Frank T.  
 Walterhouse, Mrs. H. H.

Davis, Mrs. William H. New Market  
 Kindell, Mrs. Herschel D. New Richmond  
 Gwaltney, Mrs. L. F. Roachdale  
 Richards, Mrs. Edgar E. Russellville  
 Himebaugh, Mrs. Gilbert Veedersburg  
 Rusk, Mrs. Hubert M. Wallace  
 Hendrix, Mrs. Claude. Waveland  
 Johnson, Mrs. Dale. Waynetown  
 Parker, Mrs. Carl B. Wingate

MORGAN COUNTY

Martinsville

Dickens, Mrs. K. L. 95 W. Jackson  
 Eisenberg, Mrs. David 340 E. Cunningham  
 Gray, Mrs. Leon. 260 N. Ohio

Miller, Mrs. Ray 290 E. Washington  
 Pitkin, Mrs. Edward M. 309 E. Washington  
 Pitkin, Mrs. McKendree C. 440 E. Washington  
 Sweet, Mrs. Austin. 260 N. Wayne

Mooresville

Comer, Mrs. C. W.  
 Comer, Mrs. Kenneth  
 VanBokkelen, Mrs. Robert  
 Willan, Mrs. Horace 109 S. Jefferson

Murphy, Mrs. Pat. Morgantown

NORTHEASTERN  
ACADEMY

Albion

Bowman, Mrs. Charles M.  
 Morr, Mrs. John W.  
 Nash, Mrs. Justin R.

Angola

Barton, Mrs. Robert  
 Hartman, Mrs. John  
 Mason, Mrs. Donald G.

Thill, Mrs. Leonard J. Ashley  
 Rogers, Mrs. E. E. Auburn  
 Sanders, Mrs. Jesse A. Auburn  
 Sneary, Mrs. Kenneth D. Avilla  
 Hathaway, Mrs. Clayton. Butler  
 Weirich, Mrs. Charles L. Butler  
 Robertson, Mrs. William 316 Wabash, Chesterton

Garrett

Jinnings, Mrs. Loren E.  
 Kantzer, Mrs. Floyd B.  
 Reynolds, Mrs. D. Monroe  
 Reynolds, Mrs. Russel P.

Kendallville

Gutstein, Mrs. Richard R.  
 Hardy, Mrs. F. C.  
 Lawson, Mrs. Isaac H.  
 Munk, Mrs. Cleorie E.  
 Seybert, Mrs. Joseph D.  
 Williams, Mrs. Harold O.

Alford, Mrs. James. Hamilton  
 Wade, Mrs. Alfred A. Howe  
 Schutt, Mrs. James B. Ligonier  
 Stultz, Mrs. Quentin F. Ligonier  
 Fipp, Mrs. August L. Rome City  
 Hildebrand, Mrs. William. Topeka  
 Lehman, Mrs. Kenneth M. Topeka  
 Showalter, Mrs. John P. Waterloo  
 Pulskamp, Mrs. Bertrand Wolcottville

Luckey, Mrs. Robert. Wolf Lake

OWEN-MONROE  
COUNTIES

Bloomington

Austin, Mrs. Esther. 114 S. Grant  
 Baxter, Mrs. Neal E. 515 N. Washington  
 Borland, Mrs. Ray. Moores Pike  
 Buckingham, Mrs. Richard E. 705 S. Fess  
 DeMotte, Mrs. Russell A. 904 S. Rose

Estes, Mrs. Ambrose 521 S. Mitchell  
 Fowler, Mrs. Ross. 709 Anita  
 Geiger, Mrs. Dillon. N. Fee Lane  
 Hardtke, Mrs. Eldred F. 610 E. Cottage Grove  
 Holland, Mrs. Charles 712 N. Washington  
 Holland, Mrs. J. E. P. 316 N. Washington  
 Holland, Mrs. Philip 514 N. College  
 Karsell, Mrs. Wm. A. 700 Highland  
 Lyons, Mrs. Robert. Unionville Rd.  
 Marchant, Mrs. Clarence 350 S. College  
 Myers, Mrs. B. D. 424 N. Walnut  
 Pizzo, Mrs. Anthony. 326 N. Jordan  
 Poolitsan, Mrs. George. 619 E. 9th  
 Prosser, Mrs. Wm. 1211 Maxwell Lane

Quarles, Mrs. E. Bryan 811 S. Woodlawn  
 Ramsey, Mrs. Hugh. 619 E. 1st  
 Reed, Mrs. Wm. 1215 Atwater  
 Rogers, Mrs. Floyd. 804 E. 8th  
 Ross, Mrs. Ben. Martinsville Rd.  
 Schell, Mrs. H. D. 801 E. 7th  
 Sibbitt, Mrs. J. W. 805 S. Henderson  
 Smith, Mrs. Herschel Martinsville Rd.  
 Smith, Mrs. Paul. 812 N. College  
 Spencer, Mrs. Beaufort. 816 E. 8th  
 Stangle, Mrs. Wm. 1818 E. 3rd  
 Topoligus, Mrs. James 603 N. Walnut  
 Tripp, Mrs. H. D. 515 N. Park  
 Wilson, Mrs. T. L. Nashville Rd.

Stouder, Mrs. Charles. Gosport  
 Mitchell, Mrs. George L. Smithville

Brown, Mrs. Marcel S. 358 N. Washington, Spencer  
 Smith, Mrs. F. R. 448 Lovers Lane, Spencer

PARKE-VERMILLION  
COUNTIES

Clinton

Casebeer, Mrs. P. Fourth St.  
 Evans, Mrs. F. Elm St.  
 Gerrish, Mrs. W. D.  
 Kercheval, Mrs. J. M. Fifth St.  
 Rosenfeld, Mrs. N. B. Blackman St.  
 White, Mrs. I. D.

Britton, Mrs. W. D. Montezuma  
 Saunders, Mrs. J. L. Newport  
 Johnson, Mrs. W. A. Perrysville  
 Rockville

Bloomer, Mrs. J. R. N. Market  
 Bloomer, Mrs. R. S. W. York  
 Dowell, Mrs. E. H. 705 Ohio  
 Harstad, Mrs. C. W. High  
 Merrell, Mrs. B. M. S. Market  
 Pirkle, Mrs. H. B. State Sanitorium  
 Staff, Mrs. R. A. State Sanitorium

PERRY COUNTY

Bush, Mrs. Hargis R. 6th St., Cannelton



**PERRY COUNTY**

(Continued)

**Tell City**

Coultas, Mrs. P. J. . . . . 809 Main  
Dome, Mrs. Hardin S. . . . 147 11th  
Dukes, Mrs. David A. . . . 521 Main  
Glenn, Mrs. F. C. . . . . 436 Main  
James, Mrs. N. A. . . . . 740 9th  
Lashley, Mrs. D. L. . . . . 606 9th  
Lally, Mrs. B. V. . . . . 622 Main  
Lohoff, Mrs. Lewis C. . . . 415 14th  
Neifert, Mrs. Noel L. . . . S. Blum

Snyder, Mrs. E. R. . . . . Troy

**PUTNAM COUNTY****Bainbridge**

Veach, Mrs. Lester W.  
Veach, Mrs. Richard L.

Gray, Mrs. Clyde. . . . . Cloverdale

**Greencastle**

Dettloff, Mrs. Fredrick R.

W. Walnut

Dobbs, Mrs. O. D. . . . . R. R. 2  
Fuson, Mrs. W. J.

108 Northwood Blvd.

Hutcheson, Mrs. Walter R.

125 E. Washington

Johnson, Mrs. James B. 207 Poplar

Parker, Mrs. George F. . . . R. R. 2

Rhea, Mrs. Gilbert D.

126 E. Washington

Steele, Mrs. Dick J.

207 Northwood Blvd.

Schauwecker, Mrs. Cleon M.

Greenwood Ave.

Tennis, Mrs. George T.

602 S. Jackson

Tipton, Mrs. William R.

203 Northwood Blvd.

Wiseman, Mrs. V. Earle 6 Durham

Huckleberry, Mrs. Carl

Putnamville

Gwaltney, Mrs. L. F. . . . Roachdale

**RIPLEY COUNTY**

Hisrich, Mrs. L. W. . . . . Batesville

Lippoldt, Mrs. C. L. . . . . Batesville

Hunter, Mrs. G. L. . . . . Milan

Daley, Mrs. Edward H. Oldenburg

Row, Mrs. George . . . . . Osgood

Smith, Mrs. Lee R. . . . . Osgood

McConnell, Mrs. William Sunman

Moran, Mrs. N. D. . . . . Versailles

**RUSH COUNTY**

McNabb, Mrs. George . . Carthage

Worth, Mrs. C. Willard . . . Milroy

**Rushville**

Atkins, Mrs. C. C. . . . 410 N. Perkins

Corpe, Mrs. Kenneth F. . . . R. R. 4

Dean, Mrs. Donald I. . . . 310 E. 5th

Denny, Mrs. Melvin . . . 124 E. 12th

Ellis, Mrs. Davis . . . . 543 W. 11th

Green, Mrs. Frank . . . 516 N. Morgan

Green, Mrs. Charles . . . 912 N. Main

Johnson, Mrs. Robert B.

841 N. Harrison

Kennedy, Mrs. R. O. . . 1004 N. Main

Kiplinger, Mrs. J. R. . . 1301 N. Main

Lee, Mrs. John . . . . 914 N. Morgan

Nutter, Mrs. W. H.

1003 N. Morgan

Shanks, Mrs. Roy E.

1110 N. Morgan

Truman, Mrs. Michel

733 N. Morgan

**SHELBY COUNTY**

Nigh, Mrs. R. M. . . . . Fairland

Davis, Mrs. John A. . . . Flat Rock

Miller, Mrs. Frank H. . . Morristown

**Shelbyville**

Barnum, Mrs. Emerson

110 E. Hendricks

Bass, Mrs. F. E.

169 W. Washington

Billman, Mrs. Gust S. . . . R. R. 2

Dalton, Mrs. Wilson L.

401 Sunset Dr.

Gehres, Mrs. Robert W. 610 Shelby

Grove, Mrs. E. G.

242 W. Broadway

Inlow, Mrs. C. Fred

48 E. Mechanic

Inlow, Mrs. Herbert H.

212 N. Harrison

Inlow, Mrs. W. D. . . . Spring Hill Rd.

Miller, Mrs. R. C. 17 W. Mechanic

McFadden, Mrs. Walter C.

28 W. Mechanic

Phares, Miss Frances

408 S. Harrison

Richard, Mrs. Norman F.

45 W. Washington

Scott, Mrs. V. B. . . . . R. R. 2

Silbert, Mrs. David B. 623 S. West

Spindler, Mrs. Robert D.

165 W. Mechanic

Tindall, Mrs. Paul R.

164 W. Franklin

Tindall, Mrs. W. R. 616 S. Harrison

Whitcomb, Mrs. Roger F.

413 W. South

**ST. JOSEPH COUNTY**

Thornton, Mrs. M. J.

R. R. 2, Bremen

**Mishawaka**

Christophel, Mrs. W. B.

527 Lincolnway E.

Doan, Dr. Anna . . . . 210 S. Race

Duvall, Mrs. W. N. . . 714 N. Mason

Ganser, Mrs. Richard A. 409 E. 3rd

Graham, Mrs. Henry J. 423 W. 3rd

Goethals, Mrs. C. J.

602 Lincolnway W.

Logan, Mrs. F. W.

304 Lincolnway E.

Martin, Mrs. Charles F. Jr.

2125 Linden

McDonald, Mrs. R. M.

E. Jefferson Rd.

Miller, Mrs. William E.

1020 Wilson Blvd.

Orr, Mrs. W. Robert

1335 Prospect Dr.

Proudfit, Mrs. C. H. . . 1135 E. 3rd

Rosenwasser, Mrs. Jacob

415 Indiana

Sirlin, Mrs. Edward M.

R. R. 19, E. Jefferson Rd.

Spalding, Mrs. Wendell L.

617 Webster

Templeton, Mrs. Ames R.

522 Calhoun

Walters, Mrs. Charles E.

111 S. Cedar

Walerko, Mrs. Frank . . 626 Indiana

Ward, Mrs. James W.

316 Lincolnway E.

Whitlock, Mrs. Merle E. 123 W. 4th

Wurster, Mrs. H. C. . . . 221 E. 3rd

Wygant, Mrs. M. D. . . . R. R. 1

Wyland, Mrs. B. J. . . . 510 Calhoun

Zimmer, Mrs. H. J.

333 Edgewater Dr.

Bassler, Mrs. C. R.

R. R. 4, Niles, Mich.

Houser, Mrs. D. S.

R. R. 2, Box 167, North Liberty

Cline, Mrs. Kenneth L. . . . Wyatt

**South Bend**

A

Abel, Mrs. J. A. . . . 825 W. Colfax

Acker, Mrs. Robert B.

103 S. Ironwood

Arisman, Mrs. R. K. 1615 E. Colfax

B

Baker, Mrs. Walter . . 49 W. More-

land St., Phoenix, Ariz.

Bosenbury, Mrs. Charles S.

3235 Riviera Dr., Coral Gables,

Fla.

Balla, Mrs. Morris . . 1516 E. Wayne

Baran, Mrs. Charles . . 128 Tasher

Bennett, Mrs. Jene R.

1072 Woodward

Berke, Mrs. Robt. D.

2510 Erskine Blvd.

Biasini, Mrs. B. A.

403 Dixie Hwy., North

Bickel, Mrs. David A.

1335 E. Wayne St. No.

Birmingham, Mrs. P. J.

1126 E. Irvington

Bishop, Mrs. C. A.

1301 Garland Rd.

Bixler, Mrs. Louis C. 1817 Portage

Blackburn, Mrs. Erwin

1343 E. LaSalle

Bodnar, Mrs. Leslie M. . 810 Arch

Bolka, Mrs. B. J.

203 Sylvan Glen Dr.

Borough, Mrs. L. D. 1726 McKinley

Bryan, Mrs. Robert J.

604 E. Ewing

Buchanan, Mrs. Wallace D.

1351 E. South

Buechner, Mrs. Fred W.

603 W. Marion

Bussard, Mrs. C. F.

329 W. Madison

Bussard, Mrs. Frank

1332 E. Monroe

C

Carter, Mrs. F. R. N.

2000 E. Jefferson Blvd.

Clark, Mrs. Stanley A.

1242 E. Jefferson Blvd.

Clark, Mrs. W. H.

1336 E. Wayne, No.

Condit, Mrs. D. H. . . 1521 E. Wayne

Cook, Mrs. Gordon C.

1433 Mishawaka

Custer, Mrs. Edward W.

1111 Darden Rd.

### ST. JOSEPH COUNTY (South Bend—Continued)

#### D

Dietl, Mrs. Ernest L.  
216 S. Coquillard Dr.  
Dodd, Mrs. Robert D. 1007 Kinyon  
Dolezal, Mrs. Bernard J.  
814 Turnock  
Donnelly, Mrs. Everett  
R. R. 6, Box 51B, Miami Rd.  
Duggan, Mrs. James A.  
110 Peashway  
Dunlap, Mrs. D. Logan  
123 North Shore Dr.

#### E

Edwards, Mrs. Bernard E.  
1341 E. Wayne, No.  
Egan, Mrs. Sherman L.  
944 Riverside Dr.  
Ellison, Mrs. Alfred Dragoon Trail  
English, Mrs. J. Paul 1317 Wall  
Erickson, Mrs. G. Walter  
217 Wildmere Dr.  
Erickson, Mrs. L. G.  
1322 E. Wayne, No.

#### F

Faltin, Mrs. L.  
302 S. Coquillard Dr.  
Feldman, Mrs. Max 1921 Miami  
Filipek, Mrs. Walter J.  
2513 Lincolnway W.  
Firestein, Mrs. Ben Z.  
508 W. Colfax  
Fish, Mrs. C. M. 119 Marquette  
Fisher, Mrs. L. F. 1717 E. Colfax  
Frank, Mrs. L. L.  
534 N. Lafayette Blvd.  
Frash, Mrs. D. W.  
1235 E. Wayne, So.  
Frey, Mrs. W. B.  
617 Northwood Dr.  
Friedman, Mrs. Morris S.  
1601 E. Cedar

#### G

Gates, Mrs. George E.  
411 W. North Shore Dr.  
Gilman, Mrs. Marcus M.  
2120 E. Jefferson Blvd.  
Giordano, Mrs. A. S. 1222 25th  
Godersky, Mrs. George  
2744 Sampson  
Goraczewski, Mrs. T. C.  
1016 W. Washington  
Green, Mrs. George F.  
1515 E. Wayne  
Green, Mrs. Norvel E.  
1726 E. LaSalle  
Grillo, Mrs. Donald 1832 N. Adams  
Grorud, Mrs. Alton C.  
129 W. North Shore Dr.

#### H

Haley, Mrs. Paul E.  
R. R. 2, Country Club Dr.  
Hall, Mrs. James M. 1022 Rose  
Hamilton, Mrs. Charles O.  
1498 Northern  
Harmon, Mrs. V. E.  
3221 Mishawaka  
Helman, Mrs. Harry W.  
120 W. Franklin Pl.  
Hewitt, Mrs. Marshall I.  
210 S. Coquillard Dr.  
Hilbert, Mrs. John W.  
410 W. Washington

Hillman, Mrs. Marion W.  
1516 Marquette Blvd.  
Hillman, Mrs. W. H.  
1317 Marquette Blvd.  
Hyde, Mrs. C. C. 1521 E. Colfax

#### K

Kamm, Mrs. Bernard  
1402 E. Washington  
Karn, Mrs. John W.  
425 Napoleon Blvd.  
Klahr, Mrs. Ellsworth E.  
1422 McKinley  
Knode, Mrs. K. T.  
101 E. North Shore Dr.  
Kramer, Mrs. A. A. 1519 Miami

#### L

Lane, Mrs. William H. 845 Park  
Lang, Mrs. Joseph E.  
505 Dixie Hwy., No.  
Langenbahn, Mrs. Carl J.  
1339 E. South  
Lent, Mrs. E. J. 125 W. Marion  
Lionberger, Mrs. John R.  
1224 E. Wayne, No.  
Lindquist, Mrs. N. S. 917 Blaine  
Liss, Mrs. Emanuel  
1612 E. Madison

Liston, Mrs. Ann  
415 St. Joseph Bank Bldg.  
Lockhart, Mrs. Philip 409 S. 26th  
Ludwick, Mrs. Harry 730 Park  
Luginbill, Mrs. Howard  
506 E. Ewing

#### M

McCraley, Mrs. W. J.  
2420 Erskine Blvd.  
McMeel, Mrs. J. E.  
315 E. Corby Blvd.  
Metcalf, Mrs. G. E.  
1209 E. Wayne, No.  
Miller, Mrs. Milo K.  
1714 E. Madison  
Mueller, Mrs. H. M.  
2802 Beechwood Lane  
Murphy, Mrs. Eugene C.  
1411 Sunnymede

#### N-O

Nelson, Mrs. F. D.  
414 Willow Run Rd.  
Nelson, Mrs. Raymond E.  
1909 E. Madison  
Olson, Mrs. Kenneth  
1228 E. Woodside

#### P

Parke, Mrs. D. Davis 828 Sorin  
Pauszek, Mrs. Thomas B.  
916 Riverside Dr.  
Petrass, Mrs. Andrew  
R. R. 2, Box 47  
Plain, Mrs. George  
2280 Ponader Dr.  
Pyle, Mrs. H. Dale  
115 N. Sunnyside

#### R

Rigley, Mrs. Edward L.  
2161 Dixie Hwy., No.  
Rodin, Mrs. H. H.  
1138 E. Wayne, So.  
Rosenheimer, Mrs. George M.  
1425 E. Woodside  
Rubens, Mrs. Eli 1331 E. Victoria  
Rudolph, Mrs. Carl  
2016 E. Madison

#### S

Sanderson, Mrs. Robert B.  
1331 Sunnymede  
Sandoek, Mrs. I. 125 W. Marion  
Sandoek, Mrs. Louis E.  
310 S. Sunnyside  
Sandoz, Mrs. H. H.  
239 S. Hawthorne Dr.  
Sandoz, Mrs. Louis A.  
304 S. Twyckenham Dr.  
Savery, Mrs. Charles E.  
R. R. 5, Box 645  
Schiller, Mrs. Herbert A.  
1813 E. Cedar  
Scott, Mrs. Frank M.  
1220 E. Woodside  
Selby, Mrs. K. E.  
1327 E. Wayne, No.  
Sennett, Mrs. C. M. 1129 Belmont  
Sensenich, Mrs. R. L. 128 S. Scott  
Shelley, Mrs. Edward S.  
1130 W. Washington  
Slominski, Mrs. Harry H.  
1862 College  
Spenner, Mrs. R. W. 1917 Bader  
Stiver, Mrs. Dan D. 1329 Belmont  
Stratigos, Mrs. Joseph S.  
2602 South Bend

#### T

Thompson, Mrs. John M.  
1618 Cedar  
Traver, Mrs. P. C.  
1010 Riverside Dr.  
V-W-Z  
Vurpillat, Mrs. F. J. 2102 E. Cedar  
Weiss, Mrs. Eugene  
2517 S. Michigan  
Wilson, Mrs. James M.  
1416 E. Monroe  
Wilson, Mrs. James L.  
1403 E. Jefferson Blvd.  
Zeiger, Mrs. Irwin L.  
1205 E. Irvington

### TIPTON COUNTY

Cotton, Mrs. Stanley Goldsmith  
Stouder, Mrs. Albert Kempton  
Dunham, Mrs. Wilbur Kempton

#### Tipton

Burkhardt, Mrs. A. E. 233 N. Main  
Burkhardt, Mrs. B. A. 328 N. West  
Carter, Mrs. Jean 215 Green  
Compton, Mrs. George  
315 W. Jefferson  
Gossard, Mrs. M. B. 203 N. West  
Kurtz, Mrs. William A. 134 Green  
Overman, Mrs. F. V.  
222 W. Jefferson  
Warne, Mrs. George 210 N. West

Tranter, Mrs. Wm. F. Sharpsville  
Moser, Mrs. E. B. Windfall  
Ericson, Mrs. Lorene Windfall

### TIPPECANOE COUNTY

Derhammer, Mrs. G. L. Brookston  
Gish, Mrs. H. M. Brookston

#### Lafayette

Beeler, Mrs. J. Moss  
Box 308, Wabash Valley San.  
Clauser, Mrs. Mary S. 2020 Union  
Dubois, Mrs. Ramon  
519 Calvert Lane



### TIPPECANOE COUNTY (Lafayette—Continued)

Flack, Mrs. R. A. . . . . 627 Central  
Frey, Mrs. Harley . . . 927 Highland  
Graham, Mrs. Thomas . . 1213 Wea  
Gripe, Mrs. Richard . . . 1623 S. 5th  
Harter, Mrs. Eli B. . . . . 918 King  
Hunsberger, Mrs. W. Glenn  
506 S. 7th  
Johnson, Mrs. Herbert . . 1405 S. 5th  
Jones, Mrs. David . . . . 2055 S. 9th  
Karberg, Mrs. Richard J.  
1600 Potomac  
Klepinger, Mrs. Harry E.  
909 N. 21st  
Marsh, Mrs. George  
Happy Hollow, R. R. 1  
McAdams, Mrs. Hugh  
1411 Sunset Dr.  
McClelland, Mrs. D. C.  
1021 Highland  
Morrison, Mrs. J. S. . . . 422 N. 7th  
Neumann, Mrs. Kenneth  
1410 S. 18th  
Ratcliff, Mrs. Frank W. . . 100 Wea  
Rothrock, Mrs. Philip . . 2061 S. 9th  
Sholty, Mrs. William  
R. R. 8, Shadeland Farm Rd.  
Trout, Mrs. Carl J. . . . . 800 State  
VanReed, Mrs. Earl . . . . 806 9th  
Vermilya, Mrs. R. W. . . . 1215 King  
West Lafayette  
Bayley, Mrs. William . . . 622 Rose  
Burkle, Mrs. John C.  
121 University  
Calvert, Mrs. Raymond R.  
308 Park Lane  
Coyner, Mrs. A. B. . . . . 403 Russel  
Engeler, Mrs. James E.  
1316 N. Grant  
Ferguson, Mrs. William B.  
704 Bexley Rd.  
Harden, Mrs. Murray  
610 Carrolton Blvd.  
Holladay, Mrs. L. J.  
227 S. Salisbury  
Hughes, Mrs. Richard R.  
908 Carrolton Blvd.  
Johnson, Mrs. Lowell . . 492 Maple  
Klatch, Mrs. Ben Z. . . . . 210 Waldron  
Loop, Mrs. Fredrick . . . 119 Leslie  
McFadden, Mrs. James  
240 S. Chauncey  
Miller, Mrs. Roland  
600 Ridgewood Dr.  
Peyton, Mrs. Frank W.  
612 Ridgewood Dr.  
Stahl, Mrs. E. T. . . . . 324 Park Lane  
Washburn, Mrs. W. W.  
209 Forest Hill Dr.

---

Houser, Mrs. Wayne W. . . . Monon  
McClure, Mrs. S. F. . . . . Monon  
Carney, Mrs. John C. . . . Monticello  
Morris, Mrs. W. V. . . . . Monticello  
Combs, Mrs. Nelson . . . . Mulberry  
Mayfield, Mrs. C. H. . . . Reynolds  
Mitchell, Mrs. E. T. . . . . Romney  
Babb, Mrs. Forest T. . . . . Stockwell

### VANDEBURGH COUNTY

Stover, Mrs. Wendel C. . . Boonville  
Zwickel, Mrs. R. E.  
1782 Wilton Rd., Cleveland, O.

### Evansville

A  
Acre, Mrs. Robert R. . . 2311 Lincoln  
Adler, Mrs. Ray N. . . . 1660 Lincoln  
Allenbaugh, Mrs. A. E.  
2318 E. Mulberry  
Anderson, Mrs. Dwight W.  
805 E. Powell  
Antes, Mrs. Earl H.  
1201 Bonnieview Dr.  
Austin, Mrs. Eugene W.  
2163 Bayard Pk. Dr.

B  
Baker, Mrs. J. S.  
2670 Stringtown Rd.  
Baker, Mrs. Mason  
1428 Lant Circle  
Barclay, Mrs. I. C. . . . 1215 Parrett  
Barnhart, Mrs. Willard T.  
507 Boeke Rd.  
Bennett, Mrs. Abner P.  
306 S. Weinbach  
Bissonette, Mrs. Roger P.  
3108 E. Walnut  
Brockmole, Mrs. Arnold W.  
700 Mary  
Bryan, Mrs. Stanton L.  
3211 E. Mulberry  
Beuhner, Mrs. Donald  
1543 McArthur Circle  
Buchholz, Mrs. Ransom R.  
1023 Taylor  
Buikstra, Mrs. C. R.  
Darmstadt Rd.

C  
Cacia, Mrs. John J.  
420 S. Boeke Rd.  
Caldwell, Mrs. William C.  
643 College Hwy.  
Clements, Mrs. A. F. . . 3315 Lincoln  
Clouse, Mrs. Paul A.  
2066 Bayard Pk. Dr.  
Cockrum, Mrs. William M.  
1414 Parkside Dr.  
Coleman, Mrs. Joseph E.  
1725 Sweetzer  
Combs, Mrs. Herman  
R. R. 1, Box 561  
Combs, Mrs. P. B. . . . . 4109 Lincoln  
Corcoran, Mrs. P. J. V.  
2412 E. Chandler  
Crane, Mrs. A. L. . . . . Kratzville Rd.  
Crawford, Mrs. James  
2713 N. Shore Dr.  
Crevello, Mrs. Albert J.  
1664 Lincoln  
Crimm, Mrs. Paul D.  
Boehne Hospital  
Cullnane, Mrs. Chris W.  
3020 Mt. Vernon Rd.

D  
Daves, Mrs. W. Lawrence  
708 College Hwy.  
Deems, Mrs. Myers  
741 Bayard Pk. Dr.  
Denzer, Mrs. Edward K.  
Outer Lincoln Ave.  
Denzer, Mrs. W. O. . . . 923 Bellemeade  
Dieckman, Mrs. Herbert S.  
Harrelton Court  
Dodd, Mrs. R. K.  
New Green River Rd.  
Dycus, Mrs. Walter A.  
3309 W. Michigan

Dyer, Mrs. Wallace K.  
812 St. James  
Dyer, Mrs. Wallace K. Sr.  
602 S. E. Riverside Dr.

E  
Ehrich, Mrs. William S.  
1500 S. Kentucky  
Eisterhold, Mrs. John A.  
Koring Rd.  
Engel, Mrs. Edgar L. . . 852 E. Gum

F  
Faul, Mrs. Henry . . . . 725 S. Willow Rd.  
Fenneman, Mrs. Robert J.  
851 Lincoln  
Fickas, Mrs. Dallas . . . 913 E. Gum  
Fisher, Mrs. William C.  
1319 S. Kentucky  
FitzGerald, Mrs. Maurice D.  
924 Bayard Pk. Dr.  
Fitzsimmons, Mrs. E. L.  
500 S. Boeke Rd.  
Flinn, Mrs. John H. . . . 551 Ruston  
French, Mrs. William G.  
844 Hoosier

G  
Garland, Mrs. E. A. . . . Plaza Dr.  
Gaul, Mrs. L. Edward  
508 S. Boeke Rd.  
Griep, Mrs. Arthur H. . . 2024 Lincoln

H  
Hammond, Mrs. R. Case  
1221 Ravenswood Dr.  
Hare, Mrs. Daniel M. . . 2112 Lincoln  
Hart, Mrs. Paul. . . . . 910 E. Blackford  
Hartley, Mrs. C. A. Jr.  
1300 S. Kentucky  
Hartz, Mrs. F. Minton  
632 S. Willow Rd.  
Healy, Mrs. William F.  
722 S. Willow Rd.  
Hefti, Mrs. Karl . . . . . Hezmer Rd.  
Heinrich, Mrs. Weston  
2012 E. Chandler  
Herrmann, Mrs. Gordon T.  
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# THE JOURNAL

OF THE

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### THE YEAR BOOK—1952 EDITION

**T**HIS is the sixth edition of the Indiana Medical Year Book. It has been assembled on the same general principles as the preceding issues, to provide a reference work for use by physicians, nurses and hospitals. It is bound with a durable cover in order to preserve its integrity, and is faced with the calendar for the next twelve months to symbolize its usefulness throughout the year.

This issue is integrated with the previous numbers by the inclusion of a cumulative index for all six Year Books. Many of the reference articles published in past years are valid and do not require republication. Access to them will be simplified by use of the index.

The membership rosters have been carefully checked and are arranged both alphabetically and by county societies. The names of all members of the association in good standing on June 1, 1952, are listed.

The Constitution and By-Laws of our association undergoes changes each year. The up-to-date form of this important document is presented, complete with the latest amendments.

The lead article, entitled "The A. M. A.—A Public Service Organization," is an address which Dr. E. J. McCormick, President-elect of the American Medical Association, delivered at the Annual Conference of County Medical Society Officers on March 2, 1952.

This address and the discussion which followed it is an inspiring and informing presentation which should be read by all physicians. It was received with enthusiasm by the conference. It is recommended as an outstanding explanation of the A.M.A. as a public service organization.

Mr. Albert Stump, legal counsel for the association, together with his associate, Mr. Byron Emswiler, have contributed an informative discussion entitled "Income Tax and Referral Fees."

In July 1950 an article entitled "Determination of Disability and Impairment" was presented by the chairman of the Industrial Board of Indiana. Due to amendments in the law since that time, some of the statutory provisions have been changed. These are outlined in this issue in a report by the Committee on Industrial Health.



## President's Page



THE "Greatest Show on Earth," or rather I should specify, the greatest medical show on earth, was held in Chicago the week of June the eighth.

This 101st anniversary of the American Medical Association was stupendous and certainly required a great deal of planning and teamwork to assure its success. A vote of thanks and confidence is tendered to the officers and management for all their efforts.

In addition to the exhibits, lectures and demonstrations, there were two outstanding sessions of which less than five hundred of the several thousands who attended the convention had any knowledge. These two meetings: the first, Sunday, June 8 at noon, a luncheon as a tribute to Dr. Joseph Lawrence who will retire September first as the chief of the Washington Office, and the second, The Conference of Presidents and other Officers of State Medical Associations.

The luncheon as a tribute to Doctor Lawrence was a well deserved compliment for the excellent job he and his staff have done in Washington.

The A.M.A. had no information bureau or legislative branch in Washington until eight years ago when Doctor Lawrence started with one stenographer. With a well planned objective the office has grown until now there are eighteen employees. The method of approach to the legislators was one of rendering a service in a constructive manner rather than exhibiting an attitude of belligerence. That conservative method has gained the respect of a great many Senators and Congressmen, even among those whose political affiliation seems to require a difference of opinion.

The United Health League which was organized by Dr. Dwight Murray and some others about nine or ten years ago for the purpose of placing a representative in Washington for legislative information and activities for the medical profession, upon realizing that they had accomplished their objective when the A.M.A. opened the office by Doctor Lawrence, disbanded and have supported the A.M.A. office to the fullest extent.

I feel sure that any one who attended the luncheon could have but one idea and that is that the A.M.A. Washington Office has rendered a magnificent service to the general public and the doctors of the nation. The office has the respect of the members of the Senate and House and there is ample personnel to observe, analyze and suggest necessary changes in legislation.

If we are to grow and succeed we must remain united and not be misled by statements of uncertainty and conjecture.

"United we stand, divided we fall."

*William Wright*



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J. M. Pfeifer, M.D.  
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Loren E. Jinnings, M.D.  
Floyd B. Kantzer, M.D.  
D. Monroe Reynolds, M.D.  
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L. H. Simmons, M.D.  
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Oscar Ludwig, M.D.  
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W. M. Matthews, M.D.  
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Earl W. Mericle, M.D.  
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G. L. Mitchell, M.D.  
Anthony Pizzo, M.D.  
G. C. Poolitson, M.D.  
Hugh S. Ramsey, M.D.  
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L. H. Hopkins, M.D.  
Lowell G. Hunter, M.D.  
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F. S. Crockett, M.D.  
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**TIPTON COUNTY**

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Eugen Eisenlohr, M.D.  
Hubert T. Goodman, M.D.  
R. N. Kabel, M.D.  
William W. Kriebel, M.D.  
A. M. Mitchell, M.D.  
G. G. Musselman, M.D.  
E. O. Nay, M.D.  
J. V. Richart, M.D.  
Burton E. Scherb, M.D.  
M. C. Topping, M.D.  
E. C. Voges, M.D.

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J. G. Kidd, M.D.  
G. W. Seward, M.D.  
J. T. Steffen, M.D.

**WARRICK COUNTY**

W. C. Stover, M.D.

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R. T. Allen, M.D.  
Paul W. Blossom, M.D.  
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D. R. Hutchison, M.D.  
George M. Johnson, M.D.  
Glen Ward Lee, M.D.  
Charles H. Loomis, M.D.  
Russell L. Malcolm, M.D.  
E. J. Meredith, M.D.  
Harry P. Ross, M.D.  
P. W. Runge, M.D.  
Morris C. Snyder, M.D.  
Will A. Thompson, M.D.  
Francis B. Warrick, M.D.  
M. W. Yencer, M.D.

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C. J. Aucreman, M.D.  
Harold D. Caylor, M.D.  
Truman E. Caylor, M.D.  
Robert G. Cook, M.D.  
T. O. Dorrance, M.D.  
Jack L. Eisaman, M.D.  
Charles E. Jackson, M.D.  
Robert L. Johnston, M.D.  
S. Bruce Kephart, M.D.  
Allen C. Nickel, M.D.  
R. M. Sherman, M.D.  
Wallace S. Tirman, M.D.  
Richard P. Yoder, M.D.

**WHITE COUNTY**

S. E. McClure, M.D.

**WHITLEY COUNTY**

John L. Langohr, M.D.

**OUT OF STATE**

J. Colin Elliott, M.D., Buchanan, Mich.  
John E. Graf, M.D., Chicago, Illinois  
T. O. Middleton, M.D., Ft. Benning, Ga.  
D. H. Murray, M.D., Napa, California  
Sydney S. Norwick, M.D., San Lorenzo, California

**MISCELLANEOUS**

Elkhart County Medical Society  
Indiana Academy of General Practice  
Indianapolis Medical Society  
Kosciusko County Medical Society  
Tippecanoe County Medical Society  
Whitley County Medical Society

## DEATHS OF INDIANA PHYSICIANS IN 1951

(Compiled by James B. Maple, M.D., chairman of Committee on Necrology)

(M) Member I.S.M.A.; (H) Honorary Member; (R) Retired

Name	Age	Date of Death	Address	Cause of Death
Brendel, Onis E. (R)	67	Jan. 3	Zionsville	Coronary occlusion, coronary arteriosclerosis, lobar pneumonia
Eberly, Karl C. (M)	63	Jan. 8	Fort Wayne	Coronary occlusion, infarction, sclerosis
Connelly, John J. (M)	59	Jan. 12	Terre Haute	Acute coronary thrombosis
Wiseheart, William H. (H)	87	Jan. 12	Colfax	Senility
Powell, Horace M., Jr. (M)	27	Jan. 13	Indianapolis	Nembutal poisoning, suicidal
Anthoulis, George D. (M)	53	Jan. 17	Gary	Auto train wreck
Anderson, John B.	78	Jan. 18	Vincennes	Pulmonary tuberculosis, diabetes mellitus
Bayley, Richard H. M. (M)	59	Jan. 18	Lafayette	Coronary thrombosis
Vandiver, Henry R. (H)	81	Jan. 20	Terre Haute	Coronary occlusion, arteriosclerosis
Ratcliff, Albert Alonzo (H)	78	Jan. 25	Kingman	Fracture 11 and 12 dorsal vertebra, myocardial failure
Grove, Emil G. (M)	78	Jan. 26	Shelbyville	Chronic myocarditis, arteriosclerosis
Hickman, Warren R. (M)	45	Jan. 29	Logansport	Primary carcinoma of the lungs with metastasis
Brown, Karl T. (H) (R)	76	Jan. 30	Muncie	Lobar pneumonia, chronic myocarditis
Price, Willard A. (H)	83	Feb. 16	Nappanee	Carcinoma of the pancreas
Rauschenbach, Chas. W. (M)	61	Feb. 17	Hammond	Generalized carcinomatosis
Mendenhall, Wm. E. (M)	80	Feb. 20	Indianapolis	Coronary embolism, virus pneumonia, chronic myocarditis
Adams, John R.	75	Feb. 26	Fort Wayne	Cerebral hemorrhage, generalized arteriosclerosis
Myers, Burton D. (R) (H)	80	Feb. 28	Bloomington	Cardiac failure
Blackwell, Samuel R.	68	Mar. 4	Gary	Pneumonia, myocardial failure
Paynter, Lawrence W. (M)	79	Mar. 5	Salem	Coronary thrombosis, arteriosclerosis, diabetes mellitus
Richardson, Everett W.	73	Mar. 7	Winslow	Coronary thrombosis
Kerr, Alvin R.	68	Mar. 11	Attica	Basilar artery thrombosis, generalized arteriosclerosis
Winters, Christian	87	Mar. 23	Fort Wayne	Myocarditis, arteriosclerosis
Conover, Earl (M)	72	Mar. 25	Evansville	Uremia, cardiovascular renal disease
Rollins, Russell (M)	56	Mar. 31	Royal Center	Adenocarcinoma of left parotid gland
Barrett, Omar H. (R)	91	Mar. 31	Knightstown	Strangulated hernia
Myers, John G. L. (R)	93	Apr. 1	Bloomington	Coronary thrombosis, cardiovascular renal disease
Gros, Hubert (M)	47	Apr. 1	Delphi	Phlebothrombosis right leg, pancreatitis
Gibbons, George L. (R)	73	Apr. 12	Mitchell	Cerebral hemorrhage, arteriosclerosis
Wilkin, William E. (R)	70	Apr. 16	South Whitley	Cerebral hemorrhage
Sweet, Austin D.	56	Apr. 22	Martinsville	Laennec's cirrhosis
King, Bernard A. (M)	69	Apr. 25	Anderson	Cerebrovascular accident
McAlister, Hector C.	55	Apr. 28	Fort Wayne	Fracture of the skull, airplane crash
Clapp, Fred R. (M)	71	Apr. 28	South Bend	Bronchogenic carcinoma
Lindquist, Nils S. (R)	76	Apr. 29	South Bend	Coronary thrombosis, arteriosclerosis
Helper, Martin (M)	39	May 10	Evansville	Hodgkins disease
Bierly, Fred R. (M)	69	May 11	Elizabeth	Coronary occlusion
Lockhead, John McLean	83	May 15	Indianapolis	Hypostatic pneumonia
Padgett, Everett E. (M)	72	May 24	Indianapolis	Coronary occlusion, arteriosclerosis
Southworth, Hamilton M.	70	May 26	Owensburg	Cerebral hemorrhage, Chronic glomerular nephritis
Hicks, Louis C. (R)	72	May 28	Indianapolis	Rheumatic heart disease
Morrow, Roy D. (M)	67	May 30	Connersville	Coronary occlusion
Duke, Benjamin E. (M)	50	June 15	Decatur	Cerebral hemorrhage, malignant hypertension
Hadden, Claude E. (M)	54	June 20	Indianapolis	Coronary occlusion
Ruch, Jake D. (M)	27	June 22	Indianapolis	Ventricular fibrillation, sensitivity to novocain and adrenalin
Duncan, William F. (H)	86	June 29	Aurora	Carcinoma of the pancreas
Farver, Moses A. (H)	84	June 29	Middlebury	Mitral stenosis



Name	Age	Date of Death	Address	Cause of Death
Lee, Allen H. (M)	56	July 1	Terre Haute	Hypertension
Schweitzer, Ada E. (H)	78	July 2	Indianapolis	Cerebral hemorrhage
Mason, Lester R. (M)	62	July 2	Muncie	Carcinoma of the gall bladder
King, Milo O. (M)	82	July 4	Rochester	Coronary occlusion
Hunn, Maro F. (M)	71	July 5	Elkhart	Apoplexy due to hypertension
Baer, Samuel W.	88	July 7	South Bend	Cardiac decompensation
Linville, Benjamin P.	69	July 7	Columbia City	Intestinal obstruction, sarcomatosis, retroperitoneal sarcoma
Steinman, Henry E.	70	July 17	Monroeville	Acute coronary occlusion, coronary thrombosis
Nichols, William E. (R) (H)	79	July 21	Hammond	Arteriosclerotic heart disease, generalized arteriosclerosis
McCaskey, George H. (M)	64	July 25	Winamac	Coronary thrombosis, generalized arteriosclerosis
Alexander, Stephen C.	72	July 27	New Albany	Cardiac block, sclerosis
Jackson, John H. (R)	85	July 31	Pleasantville	Hypostatic pneumonia, acute cholecystitis, myocarditis, generalized arteriosclerosis
Ashworth, Lewis N. (M)	55	Aug. 3	Connersville	Carcinoma of the esophagus
Blaize, Joshua L. (M)	69	Aug. 8	Sandborn	Left ventricular failure, aortic stenosis
Kistner, John W. (M)	74	Aug. 13	Elkhart	Congestive heart failure, chronic arteriosclerosis, diabetes mellitus
Davidson, William D.	44	Aug. 21	Evansville	Heart disease
Keefe, Thomas L. (M)	50	Aug. 21	Logansport	Cirrhosis of liver with massive intestinal hemorrhage
Goraczewski, Thaddeus C. (M)	44	Aug. 23	South Bend	Coronary occlusion, diabetes mellitus
Bland, Curtis (R)	78	Sept. 6	Oaktown	Hypertensive cardiovascular disease
Simons, James S. (H)	86	Sept. 8	Lyons	Coronary occlusion, hypertrophy of prostate, diabetes mellitus
Overman, Frederick V. (M)	74	Sept. 11	Tipton	Cerebral hemorrhage, hypertension, diabetes mellitus
Loring, Mark L. (M)	51	Sept. 11	Valparaiso	Barbiturate poisoning
Hagie, Franklin E. (M)	65	Sept. 12	Richmond	Myocardial insufficiency
Nixon, Jesse E.	76	Sept. 14	Portland	Cerebral hemorrhage
Miller, William E. (M)	53	Sept. 15	South Bend	Peritonitis, ulcerative colitis, hepatitis, hypostatic pneumonia
Cole, Russell E. (M)	72	Sept. 16	Muncie	Carcinoma of the liver
Hupe, Charles (H)	94	Sept. 18	Lafayette	Fracture left femur, myocardial failure
Briggs, Jesse H. (M)	70	Sept. 18	Churubusco	Carcinoma of the tongue
Dasse, Richard J.	64	Sept. 22	Logansport	Coronary occlusion, arteriosclerotic heart disease
Hutcheson, Walter R. (H)	76	Sept. 23	Greencastle	Acute coronary occlusion, diabetes mellitus
Wilson, LeRoy A.	75	Sept. 26	Michigan City	Cerebral hemorrhage, generalized arteriosclerosis
Powell, Nettie Bainbridge (H) (R)	83	Sept. 26	Marion	Cardiovascular renal disease
Bounnell, Harry M. (H)	83	Sept. 28	Waynetown	Cerebral hemorrhage, generalized arteriosclerosis
Butman, William C. (M)	71	Sept. 30	Hebron	Heart disease
Graham, Thomas G.	42	Oct. 7	Lafayette	Third degree burns, airplane accident
Puryear, J. Otway	74	Oct. 10	Gary	Bronchopneumonia, fractured rib in auto accident
Williams, Luther (R)	83	Oct. 14	Indianapolis	Coronary occlusion, hypertensive heart disease
Strange, John W. (M)	75	Oct. 15	Loogootee	Coronary occlusion
DeLong, Charles A. (H) (R)	77	Oct. 23	Gary	Nephrosclerosis, uremia
Wilson, Henry	78	Oct. 24	Fort Wayne	Pneumonia, arteriosclerotic cardiovascular disease
Ranes, John R. (M)	70	Oct. 25	Mt. Vernon	Carcinoma of the prostate
Holliday, L. Doyte	67	Oct. 29	Fairmount	Cerebral hemorrhage, arteriosclerosis
Aldridge, James W. (M)	60	Oct. 31	Covington	Myocarditis, brain hemorrhage
Noffsinger, Henry	91	Oct. 31	Union City	Uremia, generalized arteriosclerosis
Donovan, Joseph W.	31	Nov. 3	Morocco	Testicular teratoma, widespread metastasis
Kannel, John W.	83	Nov. 6	Fort Wayne	Coronary thrombosis, arteriosclerosis
Crawford, Wm. G. (R) (M)	68	Nov. 6	Terre Haute	Arteriosclerotic heart disease
Hoffman, George E.	86	Nov. 7	Rochester	Coronary embolism
Whitlatch, Irving A. (R)	69	Nov. 13	Milan	Coronary thrombosis, generalized arteriosclerosis
Witt, Lazarus L.	87	Nov. 14	Indianapolis	Severe malnutrition

Name	Age	Date of Death	Address	Cause of Death
Mavity, David E. (R) (H)	81	Nov. 16	Fowler	Fractured femur, carcinoma of the bowel
Schulz, Clarence H. (M)	50	Nov. 17	LaGrange	Cause unknown (coroner's finding)
Bigham, John C.	58	Nov. 24	Batesville	Coronary occlusion, hypertension, arteriosclerosis
Dittmer, Samuel E.	66	Dec. 1	Kouts	Myocardial infarction
Wheeler, John T. (R) (H)	84	Dec. 4	Indianapolis	Cerebral hemorrhage, generalized arteriosclerosis
Miller, Iva M. (M)	71	Dec. 5	Indianapolis	Bronchogenic carcinoma
Williams, Benjamin F.	90	Dec. 6	Marion	Bronchopneumonia, generalized arteriosclerosis
Niblack, James S.	56	Dec. 27	East Chicago	Coronary heart disease

## Deaths

**Mac Guyer Porter, M.D.**, of Elnora, died suddenly on May 12, at the age of eighty-five. He had practiced in Elnora for fifty-five years. He was a graduate of the Eclectic Medical College of Cincinnati, in 1897, and was a Senior member of the Daviess-Martin County Medical Society and the Indiana State Medical Association, and was a member of the American Medical Association.

**Louis A. Sandoz, M.D.**, of South Bend, died on May 13, at the age of fifty-six. He graduated from the University of Louisville School of Medicine in 1924, and practiced in Mishawaka before going to South Bend in 1926. Doctor Sandoz was a member of the St. Joseph County Medical Society, the Indiana State Medical Association, and the American Medical Association.

**Harry E. VanderBogart, M.D.**, of Goshen, died on May 23, after an extended illness. He was sixty-eight years of age. He was a graduate of the Hahnemann Medical College and Hospital in Chicago, in 1914, and was a veteran of World War I. Doctor VanderBogart was a member of the Elkhart County Medical Society, the Indiana State Medical Association, and the American Medical Association.

**Robert Glaser, M.D.**, of Brookville, died on May 20. He was forty-one years of age. He graduated from the St. Louis University School of Medicine in 1936 and served with the Army Medical Corps in World War II. Doctor Glaser was a member of the Fayette-Franklin County Medical Society, the Indiana State Medical Association, and the American Medical Association.

**Frank Henry Mervis, M.D.**, of East Chicago, died on May 8 after a long illness. He was sixty-one years of age. He was a graduate of the Chicago College of Medicine and Surgery, in 1914, and practiced in East Chicago before and following World War I, until his retirement four years ago. Doctor Mervis was a member of the Lake County Medical Society, the Indiana State Medical Association, and the American Medical Association.

**Bruce H. Beeler, M.D.**, of Evansville, died on May 23, at the age of sixty-four. He was a 1915 graduate of the University of Louisville School of Medicine, and had practiced in Evansville since 1922. He was a veteran of World War I, and was a member of the Vanderburgh County Medical Society, the Indiana State Medical Association, and the American Medical Association.



## News Notes

### National Life Insurance Dividends

Veterans who do not request their 1952 National Service Life Insurance dividend in cash before it is due will be notified by the Veterans Administration of the dividend amount placed on deposit to their credit.

VA said dividend notices will be mailed to such veterans after the 1952 anniversary dates of their policies—the dates when the 1952 dividend is payable. The first notices are scheduled to be mailed soon.

The notice will advise the policyholder that if the dividend credit is not applied in payment of premiums becoming due and not otherwise paid, or is disposed of in full at the insured's request within three months from the anniversary date, it will earn interest.

The authority for this procedure is Public Law 36, 82nd Congress. This law provides that on and after January 1, 1952, dividends on NSLI shall be applied in payment of premiums becoming due and not otherwise paid unless the insured has requested payment of the dividend in cash.

VA has begun to mail 1952 dividend checks to policyholders who have made requests in writing for cash payments. Approximately 5,000,000 policyholders are eligible for the \$200,000,000 dividend.

Policyholders who pay premiums to VA district offices and who request their 1952 dividend in cash will receive checks from those offices.

Policyholders in military service who are paying premiums by allotment from military pay and who request their 1952 dividend in cash, will receive their checks from the VA Central Office in Washington, D. C.

Policyholders who desire dividends paid in cash and have not yet so requested should write the VA office to which they are paying premiums, giving their full name, insurance policy numbers and the address to which they wish the dividend payment sent.

### The American Congress of Physical Medicine

The 30th annual scientific and clinical session of the American Congress of Physical Medicine will be held on August 25, 26, 27, 28 and 29, 1952 inclusive, at The Roosevelt Hotel, New York. Scientific and clinical sessions will be given on the days of August 25, 26, 27, 28 and 29. All sessions will be open to members of the medical profession in good standing with the American Medical Association. In addition to the scientific sessions, annual instruction seminars will be held. These lectures will be open to physicians as well as to therapists, who are registered with the American Registry of Physical Therapists or the American Occupational Therapy Association. Full information may be obtained by writing to the American Congress of Physical Medicine, 30 North Michigan Avenue, Chicago 2, Illinois.

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Announcement has been made of the association of **Dr. John E. Mackey** with **Dr. Charles Gillespie**, in the practice of obstetrics and gynecology. Their office is at 3209 North Meridian Street in Indianapolis. Doctor Mackey recently completed a residency in obstetrics and gynecology at Indianapolis General Hospital.

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**Dr. Philip B. Reed**, of Indianapolis, was elected president of the Central Neuropsychiatric Hospital Association at their meeting in Chicago in March.

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On July 1 **Dr. David C. Beck**, of Michigan City, opened an office in Monticello for the practice of medicine. He is a graduate of Indiana University School of Medicine, and recently completed his internship at Memorial Hospital in South Bend. He is a veteran of World War II.

Upon completion of his internship at Indiana University Medical Center, **Dr. Linus J. Minnick** has opened an office for the practice of medicine in Churubusco. He is a native of Fort Wayne, and is a graduate of Indiana University School of Medicine.

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**Dr. Charles A. Novy** has opened an office for the practice of medicine and surgery in Garrett. He is a 1946 graduate of Loyola University School of Medicine, and interned at Mercy Hospital in Chicago. Upon his release from service in the Air Force, he practiced in Chicago for two years, and then went to the VA Hospital in Fort Wayne.

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**Dr. Jerome Cope** of Louisville has opened an office in Edinburg for the practice of medicine.

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**Dr. Donald W. Schafer**, who has practiced medicine in Fort Wayne for the past five years, has gone to the Menninger Foundation School of Psychiatry in Topeka, Kansas, where he has a fellowship.

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Announcement has been made of the appointment of **Dr. Pierre C. Talbert** to the Caylor-Nickel Clinic in Bluffton. A 1944 graduate of Indiana University School of Medicine, he served his internship at Stamford Hospital, Stamford, Connecticut. After two years in the Army, Doctor Talbert served a residency in pathological anatomy at St. Joseph Hospital, Fort Wayne, and a three year residency at the Caylor-Nickel Clinic.

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**Dr. Leonard Wiatt** has opened an office for the practice of medicine in Knightstown. A native of New Palestine, he recently completed his internship in Gary.

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## *Indiana University News Notes*

The Indiana University School of Medicine and Medical Center played host to state pediatricians for an all-day meeting the latter part of April. Dr. Lyman T. Meiks, chairman of the Department of Pediatrics, was in charge of the program which consisted of case presentations by staff members and an address by Dr. Sherman Little, chief of the Othopsychiatric Department of Children's Hospital in Buffalo, New York.

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Approximately twenty county medical societies heard the monthly Telephone Seminar, Tuesday, May 6, which was presented from the Auditorium of the School of Medicine by a panel led by Dr. Sprague Gardiner. Participating in the discussion on "Cesarean Sections" were Dr. Carl P. Huber, Dr. G. W. Gustafson, Dr. C. O. McCormick, Sr, and Dr. D. L. Smith, of the School of Medicine staff, and Dr. R. W. Wilkins of Fort Wayne.

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Open house was held in the hospitals of the Medical Center Monday, May 12, in observance of National Hospital Day. In the evening students in the I. U. Training School for Nurses joined with students from other local nursing schools in the traditional Florence Nightingale program held at the Indiana World War Memorial, with Governor Henry F. Schricker as the speaker.

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Twenty-two research projects covering a wide variety of investigation on the Medical Center campus are now being financed in whole or in part by funds from the James Whitcomb Riley Memorial Association, according to an announcement made recently by Perry W. Lesh, president of the Association.

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Dr. R. N. Harger, chairman of the Department of Biochemistry and Pharmacology, gave a series of four talks on "Alcohol and Safety" at regional meetings of the Shell Oil Company employes in Huntington, Vincennes, and Louisville, recently.



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Number of Hours Residue is Retained							
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Control (No Therapy)				○ ○ ○	○ ○ ○ ○ ○ ○ ○ ○	○ ○ ○ ○ ○ ○ ○ ○	○ ○ ○
METAMUCIL	● ● ● ● ● ● ● ● ● ● ● ●	● ● ● ● ● ●	● ● ● ●	●	●		
Enemas	●	● ●	●	● ● ● ● ● ●	● ● ● ● ● ● ● ● ● ● ● ●	● ● ● ● ● ●	● ● ● ●
Antispasmodics				● ● ● ●	● ● ● ● ● ● ● ● ● ● ● ●	● ● ● ● ● ● ● ● ● ● ● ●	● ● ● ●
Mineral Oil		●		● ● ● ●	● ● ● ● ● ● ● ● ● ● ● ●	● ● ● ● ● ● ● ● ● ● ● ●	● ● ● ●



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\*Barowsky, H.: A Roentgenographic Evaluation of the Common Measures Employed in the Treatment of Colonic Stasis, Scientific Exhibit, National Gastroenterological Association, Chicago, Sept. 17-22, 1951.

RESEARCH IN THE SERVICE OF MEDICINE SEARLE

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Miss Euzolia Smart has begun her duties as director of the Medical Social Service Department, succeeding Mrs. Jane Morgan Johnson, who retired some months ago. Miss Smart will also serve as Assistant Professor in the I. U. School of Social Service.

A graduate of Meredith College, Raleigh, North Carolina, and holding an M.S. degree from the New York School of Social Work at Columbia University, Miss Smart was overseas for six years with the American Red Cross hospital service and stationed in Australia, New Guinea, the Philippines, Japan and Korea. She had been associated with the North Carolina Cerebral Palsy hospital in Durham, prior to accepting the appointment here.

Several hundred graduates of the School of Medicine and their wives gathered on the campus Wednesday, May 14, for the fifth annual Alumni Day program arranged by President Will C. Moore, Muncie, and other officers of the Medical School Alumni Association.

A feature of the day was the picnic luncheon staged on the lawn, during which time classes held informal reunions. There were scheduled gatherings for those whose numerals ended in '2' and '7'. Sightseeing buses took the visitors on tours of the Medical Center campus and hospitals in the immediate area.

Principal speaker for the afternoon program was Dr. Dwight H. Murray, a 1917 graduate, from Napa, California, who is chairman of the Board of Trustees of the American Medical Association. Doctor Murray's subject was "The American Medical Association and the Medical Schools."

During the business session Dr. Dillon Geiger, Bloomington, was installed as president of the Association for the coming year.

Dr. J. E. Dudding, practicing physician of Hope, was the guest speaker for the meeting of the Student American Medical Association held at the School of Medicine recently. Dr. Dudding spoke to the students on the subject "What General Practice is Like."

In observance of the founding of Indiana University a luncheon was held at the Hotel Severin Monday, May 12, under the auspices of the Indianapolis alumni of the university. President Herman B Wells was the luncheon speaker. Honor was paid to five members of the University staff who are retiring July 1, including J.B.H. Martin, Medical Center Administrator since 1933.

Dr. W. Foster Montgomery of the Department of Surgery left by plane for Madrid, Spain, May 17 where he was a guest lecturer at the International Surgical Seminar on Pediatric Surgery. His lecture, given in Spanish, was on "Meconium Ileus." The invitation to appear on the program was extended by Professor Alfonso de la Fuenye, of the Department of Surgery at the University of Madrid.

Members of the Medical Center staff have been attending meetings in various parts of the country during the past month. Dr. J. O. Ritchey, Dr. Charles E. Test, Dr. Glenn W. Irwin and Dr. Ralph C. Wilmore were in Cleveland for the meeting of the American College of Physicians. Dr. Randall Thompson, Dr. E. W. Shrigley and Dr. W. A. Summers were in Boston for meetings of the Society of American Bacteriologists. Dr. Samuel Hopper was in Kansas City for an annual meeting of the American Waterworks Association. The American Association of Thoracic Surgeons meeting was held in Dallas, Texas, and attended by Dr. Harris B. Shumacker and Dr. J. S. Battersby. Dr. Shumacker also attended the U. S. Public Health Service Surgery Study. Dr. Dwain N. Walcher, Dr. Paul Lurie, Dr. Malcolm Holliday and Dr. L. T. Meiks were in Virginia for the meeting of the Society for Pediatric Research and the American Pediatric Society. Dr. Glenn W. Irwin attended a meeting of the American Goiter Association. Dr. V. K. Stoelting was in Chicago for a meeting of the Illinois State Society of Anesthesiologists.





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## A.M.A. WASHINGTON OFFICE NEWS

**War Manpower Council Urges Military Deferment Through One Year of Residency**

The War Manpower Council, a citizens' organization financed by the Ford Foundation, has recommended that physicians be deferred from military service until completion of one year of residency training. The Council's report, *Student Deferment and National Policy*, lists this among its 14 recommendations made to Defense Department, Selective Service and other government agencies.

Currently, medical students are deferred through one year of internship, by which time they are subject to the Doctor-Draft law.

The Council also suggested that: (a) deferment of young fathers be ended, (2) present student deferment on the basis of aptitude tests and class standing be continued, (c) the military make the best possible use of its own scientific and technical personnel by turning many jobs over to civilians and (d) the military check into its procurement policy to see if it is using too great a proportion of scientific and engineering school graduates as line officers.

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**Dr. Bugher to Succeed Dr. Warren as  
A. E. C. Biomedical Director**

Effective June 30, Atomic Energy Commission's Division of Biology and Medicine will have a new director, Dr. John C. Bugher, who has been serving as deputy director. Dr. Bugher succeeds Dr. Shields Warren, director of the division since creation of AEC in 1947. Dr. Warren said he was resigning because "... tens of thousands of miles of traveling yearly, the stress of our continually varying and yet fascinating work, are making themselves felt." In accepting the resignation, AEC General Manager M. W. Boyer described Dr. Warren as "*one of the architects of the atomic program as it stands today.*" Dr. Warren will return full time to his post as pathologist at the New England Deaconess Hospital in Boston.

**Periodic Physical Examinations Required for Interstate Truck, Bus Drivers**

Effective July 1, new federal regulations raise the physical standards for truck, bus and taxicab drivers engaged in interstate commerce and require periodic physical examinations. The new requirements are announced by Interstate Commerce Commission in a general revision and tightening up of its safety code. The more important changes of interest to doctors include:

1. After January 1, 1954, *every driver must be physically re-examined at least once in three years*; currently only a pre-employment physical examination is required. Both employer and employe must have the physician's certificate available at all times.
2. Visual acuity of not less than 20/40 in each eye (with glasses) will be required of new men, but drivers now on the job may qualify under the current standard until January 1, 1954. (Current standard is 20/40 in one eye, 20/100 in the other).
3. The present requirement of "adequate hearing" will be supplanted by a definite measurement of hearing, which must be met without dependence on a hearing aid.

It is estimated that a million or more truck, bus and taxicab drivers come under Interstate Commerce regulation. Details may be obtained from Interstate Commerce Commission, Washington, D. C.



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## Society Reports

### INDIANA STATE MEDICAL ASSOCIATION

#### EXECUTIVE COMMITTEE

May 16, 1952

Roll call showed the following present: C. J. Clark, M.D., chairman; W. L. Portteus, M.D.; J. William Wright, M.D.; Paul D. Crimm, M.D.; Wemple Dodds, M.D.; Roy V. Myers, M.D.

Frank B. Ramsey, M.D., editor of *THE JOURNAL*; Albert Stump, attorney; James A. Waggener, executive secretary; Robert J. Amick, field secretary.

Woman's Auxiliary guests: Mrs. Hubert T. Goodman, Terre Haute, president; Mrs. Burleigh Matthew, Indianapolis, president-elect; Mrs. J. M. Sullivan, Terre Haute, treasurer; Mrs. N. E. Forsee, Jeffersonville, public relations chairman; Mrs. G. W. Dyer, Terre Haute, legislative chairman; Mrs. Harry C. Harvey, Fort Wayne, first vice-president, and Mrs. F. N. Williams, Huntingburg.

Doctor Clark asked Mrs. Goodman to take over the opening of the meeting for the purpose of reviewing the proposed program of the Auxiliary for the coming year.

Mrs. Dyer explained the legislative program and Mrs. Forsee talked about the proposed public relations program, both of which were approved by consent by the committee.

The committee suggested that the Auxiliary make an effort to meet the delegates to the state convention and to become acquainted with the members of the state legislature so that they might be prepared to talk to them on legislative matters before the next legislative session.

Mrs. Matthew reported that there are seventeen unorganized counties in the state, and the committee offered its assistance in procuring approval from county medical societies granting permission for the establishment of the Auxiliary within their county.

#### Membership Report

Number of members, May 16, 1952	3,522*
Number of members, May 16, 1951	3,443
Gain over last year	79

\* Includes:

66—in military service (gratis)
109—\$10.00 members (residents and interns)
233—senior members
1—honorary member
43—members, dues remitted by Council

#### Headquarters Office

The field secretary gave a comprehensive report on his activities during the month, stating that he had contacted officers of nineteen counties and had attended nine society meetings.

Statements of receipts and expenditures and

report on the budget for April for the association and *THE JOURNAL* were approved.

#### Treasurer's Office

Upon motion of Drs. Wright and Crimm, \$25,000.00 from the General Fund and \$5,000.00 from the Medical Defense Fund was authorized to be invested in United States Savings bonds.

1952 Annual Session, Indianapolis,

October 28, 29 and 30, 1952:

(1) *Technical exhibit:*

The report on the survey authorized by the committee among the states to determine their policy on acceptance of exhibits for their annual meetings was reviewed by the committee, and upon motion of Drs. Portteus and Wright, the committee decided to restrict all exhibits at the 1952 annual session to products having A.M.A. Council acceptance.

#### Legislative Matters

##### *National*

Upon motion of Drs. Wright and Dodds the committee approved renewal of the subscription to "The Washington Report on the Medical Sciences."

#### Organization Matters

Letter from the A.M.A. regarding status of various classifications of membership in the association was read and the committee instructed the headquarters office to notify the A.M.A. that members in these classifications are considered active members.

The matter of the association making a nomination of a physician to compete for the award of the President's Committee on Physically Handicapped was tabled upon motion of Drs. Crimm and Wright.

Requests of Dr. Herbert C. Ashmore and Dr. Earl R. Leinbach to begin practice in Hebron and Hamlet respectively were approved upon motion of Drs. Wright and Dodds, providing their requests met with the approval of the Committee on Medical and Nursing School Scholarships.

Letter from the St. Joseph County Medical Society was read.

Request for use of the mailing list by the Treasury Department was granted on motion of Drs. Wright and Crimm, providing no expense to the association is involved.

#### The Journal

*Report on advertising* was accepted by consent:

Total, May, 1951	\$2,333.53
Total, May, 1952	2,050.19

The editor discussed methods of notifying interns and residents of the subscription rate to *THE JOURNAL* and by consent it was agreed that this should be done by letter.

There being no further business, the committee adjourned to meet again at 6:00 p.m., Tuesday, June 17, 1952, at the Athenaeum, Indianapolis.



## COUNCILOR DISTRICT MEETINGS

### Ninth District

One hundred and twenty-nine physicians and their wives attended the ninth district meeting, held at the Country Club in Crawfordsville May 21. The group was addressed by Dr. J. William Wright, Indianapolis, president of the Indiana State Medical Association, and by Louis Bromfield, lecturer and author from Lucas, Ohio, who spoke on "The New Agriculture in Relation to Human Health."

The annual golf tournament got underway at 9:00 a.m. and the scientific program began at 2:00 p.m., with a paper on "ACTH and Cortisone in Acute Rheumatic Fever" by Lyman T. Meiks, M.D., of Indianapolis.

A panel composed of L. G. Montgomery, M.D., B. W. Stocking, M.D., William Sneed, Jr., M.D., and William B. Adams, M.D., all of Muncie, discussed "Pulmonary Atelectasis of the Newborn."

The afternoon session closed with a meeting of the delegates to discuss medical organization affairs.

The 1953 meeting will be held at Noblesville and the officers of the Hamilton County Society will serve as the district officers for the next meeting. Wemple Dodds, M.D., Crawfordsville, was re-elected Councilor for the district.

During the afternoon the members of the Auxiliary were entertained with a tour of the historical sites in Crawfordsville and at bridge. Mrs. H. T. Goodman, Terre Haute, president, and Mrs. Burleigh Matthew, Indianapolis, president-elect of the Auxiliary, spoke during the business session.

### Eleventh District

Meeting in the Y. W. C. A. at Kokomo, approximately seventy-five physicians of the Eleventh District held their spring district meeting. Opening with a business session at two o'clock, the group established the date of September 17, 1952, for their fall meeting, which is to be held at Logansport.

Dr. Richard P. Good, Kokomo, was elected president and Dr. C. R. Herd of Peru was re-elected secretary-treasurer.

Dr. Elton R. Clarke, Councilor, reviewed in detail the actions of the Council and the House of Delegates and gave a report on the legislative picture. Dr. J. William Wright, Indianapolis, president of the Indiana State Medical Association, spoke briefly on the Association.

For the scientific program, Dr. Stuyvesant Butler of Chicago gave a paper on "Headache," and "The Surgical Aspects of Mitral Stenosis" was discussed by Dr. Mason Sones and Dr. Donald Effler of Cleveland, Ohio.

During the afternoon members of the Auxiliary were entertained with a musical program.

The dinner speaker was Mr. Eugene Pulliam, Indianapolis, publisher of the *Indianapolis Star and News*.

# ALCOHOLISM

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## LOCAL SOCIETY REPORTS

Fayette-Franklin County Medical Society members met at the Connersville Country Club on May 13. The guest speaker was Dr. Gerson Lowenthal, from the University of Cincinnati, who spoke on "Facial Injuries." Eighteen members and one guest were present.

Fort Wayne (Allen County) Medical Society members met on May 6 at the Irene Byron Sanatorium. Dr. J. V. Sherwood, of Fort Wayne, spoke on "Clinical Diagnosis of Bronchial Obstructions," and Dr. O. T. Kidder of Fort Wayne showed a film on "Streptomycin."

Huntington County Medical Society members met in Huntington on April 1, when Dr. R. J. Schmoll, of Fort Wayne, spoke on "Infection of the Eye." Fifteen members were present.

Another meeting was held May 6 in Huntington. Twenty-one members were present to hear Dr. Louis Nie, of Indianapolis, speak on "Psychiatry."

LaPorte County Medical Society members met at the Peacock Fountain Inn at Rolling Prairie on May 15. Dr. H. N. Sanford, of Chicago, spoke on "Problems in the Care of the Newborn." Twenty-five members were present.

Noble County Medical Society members met in Kendallville on May 6. The five members present participated in the telephone seminar.

Vanderburgh County Medical Society members met on June 3 at the Hotel McCurdy in Evansville. This was a business meeting. Mr. Albert Stump, association attorney, spoke on mal-practice suits.

Wabash County Medical Society members met at Wabash on May 14. Dr. O. T. Kidder of Fort Wayne spoke on "Problems Concerning Tuberculosis." Sixteen members were present.

Washington County Medical Society members met at Washington County Memorial Hospital on May 13. Dr. P. L. Mull, of Louisville, spoke on "Electroencephalography." Seven members were present.

Whitley County Medical Society members met at Whitley County Memorial Hospital on May 13. Dr. Robert Tyler, of Columbia City, spoke on "Cation Exchange Resins." Eight members were present.

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# *Opinions From Here and There*

Prepared for your information by the Committee on Public Policy and  
Legislation of the Indiana State Medical Association

## **H.R. 7800**

There has been a lot of discussion on this piece of legislation, which was finally passed by Congress in the closing hours of the 82nd session. As reported to you last month, an agreement had been made whereby the Senate would remove the controversial section 3. This was done, as promised, but when the bill went to a joint House and Senate committee to iron out the differences, a new disability section was included, and there has been some misunderstanding regarding this. Some feel that the medical profession has lost this battle, but here are the facts.

The new section as included in the bill as passed, in effect, postpones final decision on this controversial question until next year. This new section is designed to waive payment of old age and survivor's insurance premiums by persons who are totally and permanently disabled. The House bill gave the Federal Security Administrator unusual control over medical examinations for the purpose of determining disability.

The American Medical Association had objected to this as an unwarranted grant of power, but had not objected to other parts of the bill, which raised benefits 12½ percent or \$5.00 per month, whichever was greater. The Senate bill had no provision for the waiver of premiums.

The President's signature will make the bill a law and the following is the compromise as worked out by the conferees and approved by both houses:

1. A new disability section, giving states, rather than the Federal Security Administrator, control over medical examinations for the purpose of determining total and permanent disability. It is understood the procedure would be similar to that now in effect for medical examinations of needy permanent and totally disabled persons who wish to be certified for Public Assistance grants. BUT---
  2. *The section can't go into effect until Congress has again acted upon it.* This section (but not others) will TERMINATE ON JUNE 30, 1953—ONE DAY BEFORE THE DATE SET FOR FILING OF THE FIRST CLAIMS. This self-contradictory arrangement was worked out to insure that full hearings could be held next year before the disability section could become operative. Chairman George had demanded that his Senate Finance Committee have this opportunity.
  3. Other provisions of the bill, not subject to termination with the disability section, include monthly increases of \$5 or 12½ percent, whichever is the larger, for Old Age Assistance Insurance beneficiaries; the right of a retirement age worker to earn \$75 per month without sacrifice of
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pension (present law is \$50, House asked \$70, Senate \$100); persons temporarily in military service to receive social security credit at the rate of \$160 per month earnings; U. S. payments to states for aid to needy aged, blind and disabled raised \$5 per month, payments to dependent children \$3, but states are not required to pass these payments along; these Public Assistance increases terminate September 30, 1954.

\* \* \* \* \*

**Remember this** for what it may be worth in the future: the U. S. Tax Court has ruled that mere mailing of a tax return with payment of tax does not qualify the return as being filed. (Estate of Fink vs. Commissioner, U. S. Tax Court.)

This ruling may have an important effect on the status of returns and payment of income taxes which are placed in the mail on the last day when they are due for filing in the Office of the Collector of Internal Revenue, but which do not reach that office until the day after the filing date. An example is where returns are mailed on March 15, the day when they are due for filing.

Heretofore, no penalty has been assessed when the postal date was the last day for the filing of the return. But the Tax Court in the case cited ruled the penalty applied because the return was not received in the Collector's office until the day after it should have been placed on file. (Ind. State Press Assn. Bulletin.)

\* \* \* \* \*

**Health Plank Nailed Down by Republicans.** The AMA and the various state Medical Associations made a nation-wide campaign to place the National Republican Party on record as opposing National Compulsory Health Insurance. The result is the following plank which was made a part of the platform:

"We recognize that the health of our people as well as their proper medical care cannot be maintained if subject to federal bureaucratic dictation. There should be just division of responsibility between government, the physician, the voluntary hospital, and voluntary health insurance. *We are opposed to federal compulsory health insurance with its crushing cost, wasteful inefficiency, bureaucratic dead weight, and debased standards of medical care.* We shall support those health activities by the government which stimulate the development of adequate hospital services without federal interference in local administration. We favor support of scientific research. We pledge our continuous encouragement of improved methods of assuring health protection."

\* \* \* \* \*

**British Doctors Get Pay Hike.** The 20,000 doctors under the British socialized medical set-up finally received their pay increase, which will cost taxpayers nearly \$100,000,000 between now and next March. The raise, retroactive to start of the socialized medical service in 1948, represents an average payment to each doctor of nearly \$5,000.

Doctors at present earn \$1.70 a year for every patient on their books and they can have 4,000 patients. The average, however, is 2,300. The increase will mean about \$1,500 more yearly.

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**It Happened—ILO Votes Social Security Treaty, Including Compulsory Health Insurance.** It was predicted a year ago this would be done and now the report of the International Labor Organization, which met in Geneva, has approved a convention (treaty) on minimum standards of social security in nine fields—*medical care*, sickness benefits, unemployment benefits, family benefits, maternity benefits, invalidity benefits and survivor benefits. Approval came over objection of employer delegations from many countries. The U.S. employer spokesman was quoted as saying employers would be against the entire convention because of the medical care section alone. A government may be listed as ratifying the convention if it promises to meet the requirements in four of the nine fields of social security.

The medical care section stipulates that a country ratifying must provide a system of compulsory health insurance. Lacking this, it has two alternatives: (a) private, voluntary health insurance "administered by public authorities under established regulations" set by law, or (b) private, voluntary health insurance administered by insurance companies BUT UNDER GOVERNMENT "SUPERVISION." Coverage would have to average about 50 percent of population.

\* \* \* \* \*

**"Why?" Is the Question.** It has been learned that the U. S. Delegation had sought to have the ILO conference agree that only one of the nine requirements had to be met for ratification. It is also learned that the U. S. Delegation voted in favor of the convention.

There is no time limit set for ratification by the U. S. Senate but the President and the State Department will decide whether to submit the convention for ratification. It would take a two-thirds vote for ratification but if successful would place this country under obligation to put at least four of the nine programs in action.

The U. S. Delegates are as follows: Senator Murray (D. Mont.) (of the Murray, Wagner, Dingell trio) and assistant secretary of labor Phillip M. Kaiser, representing government; George F. Delaney of American Federation of Labor, representing employees; Charles F. McCormick, president of McCormick Tea and Spice Company, Baltimore, employer representative. (This is something that should be watched—we can get socialized medicine by this method, too.)

\* \* \* \* \*

**Bills Affecting Medicine Passed by Congress.** During the closing rush of activity prior to the close of the 82nd Congress the following bills affecting medicine were approved and sent to the White House for the President's signature. 1. Bills to continue the \$100 per month special pay for military and USPHS physicians and to authorize commissions for women physicians in the regular medical corps of the three services. 2. The immigration bill, with a provision giving preferential treatment to physicians and other highly skilled

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persons. (This passed over President's veto.) 3. Legislation to allow taxpayers to deduct up to 20 percent rather than 15 percent of their gross income for contributions to charitable, educational and other organizations. 4. Appropriations for FSA and VA Administration. 5. Fair Trade. 6. Social Security amendments. 7. Mine Safety. 8. Reorganization of military reserves. 9. A GI bill for veterans with service since the start of the Korean War and extension of the Water Pollution Control Act. The Senate refused to consider emergency maternity and infant care bill, but the defense department will make a special study of this matter. The House passed a bill allowing veterans a 2-year presumptive period for psychosis, but Senate took no action.

\* \* \* \* \*

**Health Commission Witnesses Urge More Funds, Services and Facilities.**

Lay and medical witnesses, testifying at open hearings of the *President's Commission on Health Needs of the Nation*, repeatedly stressed the need for more funds, more services and more facilities. Greater use of federal funds was recommended in several fields. Here is a summary:

**RURAL HEALTH**—A method "must be found" to finance medical education for rural youths and to provide internships and preceptorships in rural settings to develop general practitioners for rural areas.

**INDUSTRIAL HEALTH**—More uniform workmen's compensation laws are needed, as well as more research and training in social, occupational and environmental medicine and hygiene.

**ENVIRONMENTAL HEALTH**—Federal grants, research and information efforts should be extended to assure state and local improvement of environmental health services.

**HEALTH OF THE AGING**—Economic status of most older people is such that "adequate medical care can be provided them only through substantial use of federal funds."

**CARE OF THE CHRONICALLY ILL**—In spite of savings from concentration of prevention, detection, control and rehabilitation, "it is probable that even larger sums, public and private, will be needed before care of chronic illness is comparable . . . to that given acute illness."

**MENTAL HEALTH**—More psychiatric training of medical students; health groups such as Blue Cross should extend their coverage to include mental disorders.

**HEALTH OF MOTHERS AND CHILDREN**—Federal grants to schools for training of personnel in maternal and child health urged, including grants for students and for teacher's salaries.

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**Deferment Limit of Six Months Recommended for Doctor Draft.**

National advisory committee to Selective Service is recommending that states place a six-month limit, subject to extension, on deferments granted physicians and dentists under doctor draft.

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# THE JOURNAL

OF THE

## INDIANA STATE MEDICAL ASSOCIATION

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### DIAGNOSIS OF EARLY GYNECOLOGIC MALIGNANCY

CHARLES H. HENDRICKS, M.D.\*

*Columbus, Ohio*

**J**HIS paper is concerned with the diagnosis of *early* gynecologic malignancy for the same reason that the fire department likes to arrive at a fire while it is small. Early arrival at the scene followed by prompt and effective action will almost inevitably keep the blaze localized and the damage minimal. When the fireman tells tales about the huge conflagrations he has battled, he is in reality talking about the *defeats* of his fire department, because the "big one that got away" represents either poor fire fighting while the blaze is small or, more often, someone's tardiness in letting the department know that a fire has started.

We know few things at present to lower the *incidence* of the "fire" of cancer, but the key to its *control* lies in our hands. We anticipate that roughly 25,000 American women will die

of female genital malignancy this year; nearly 20,000 of them could have been saved if they had been brought to adequate therapy at the onset of symptoms.

If we are fully to exploit our ability to control early cancer, there must be close cooperation between three team components. The team is made up of the educated patient, the alert diagnostician, and the trained therapist, whether he be radiologist or surgeon. The flashing scalpel of the radical pelvic surgeon, the cross-country shipment of radioisotopes in thick lead boxes labelled "Rush," and "Dangerous," these seem to be the exciting phases in the cancer fight. But neither pelvic exenteration nor any form of irradiation can save the life of even 10 percent of patients with Clinical Group IV cervical carcinoma.

The truly life-saving part of the cancer fight must be carried out by the two less dramatic members of the team, the educated patient and

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\* From the Department of Gynecology and Obstetrics, Ohio State University, College of Medicine, Columbus, Ohio.

the alert diagnostician. These two are the members who could have saved the lives of 20,000 American women this year by earlier case finding, because at best the results of the therapist will only reflect the stage to which the patient's disease had advanced at the time she was first referred to him.

We constantly read in our journals and in the lay press about new advances in cancer therapy. Let us examine the resources of the diagnostic members of the cancer-fighting team.

### The Patient

First, the patient. If she is to be a "cancer-educated" patient her cancer education must usually come from articles in the lay press, or from her own physician. Newspaper and magazine articles have been known on occasion to try the patience of physicians with half-truths and out-of-context assertions on medical problems. But whether we like these pseudomedical articles or not, our patients are going to go right on reading them. Not a few patients will come to your office because of reading such an article. After all, it does not matter what brings the patient to the physician's office for examination, just as long as she gets there. The smart physician, rather than angrily rejecting the patient's magazine gleanings in toto, uses the gleanings as a point of departure for some *real* education of the patient.

In addition to filling the role of diagnostician, then, the physician must also serve as an educator if we are to take full advantage of our knowledge of the management of cancer of the female genitalia.

The importance of the periodic gynecologic consultation reaches far beyond the pelvic examination; it represents significant opportunities in patient education. The first opportunity is the chance to sell the patient on the value of periodic examination itself. We can point out to her that the prenatal patient is happy to make an average of twelve prenatal visits per pregnancy not because she thinks there is something wrong with the pregnancy but because she recognizes the prophylactic value of such visits. When contrasted with the weekly or monthly interval of the prenatal visit, the annual or semi-annual gynecologic examination seems a reasonable expenditure of time.

The next educational possibility at the periodic check-up is that of letting the patient know that she is doing the intelligent thing. Occasionally a physician, thinking to reassure the patient, will say, "Your pelvis is so normal that I really don't know why you came." Such a statement leaves the patient skeptical about the value of her check-up visit. Or the patient may say, "I feel foolish being here, because I'm perfectly well." Here the physician can say to the patient, "You did the right thing by coming for an examination. If every patient without symptoms came for periodic examinations as you have done, the majority of female pelvic cancer could be found early enough to be cured."

Another educational opportunity is that of teaching the patient to deal respectfully but not fearfully with her symptoms. We have all had experience with the patient who allows symptoms of possible malignancy to go on unchecked because she fears her physician would tell her she has cancer. Such a woman may thus suffer more delay in diagnosis from an enlightened fear than she ordinarily would from complete and blissful ignorance. When the patient knows that most symptoms of possible malignancy are not truly due to malignancy, and that early diagnosis means an excellent chance for a cure, she will be more willing to go for an examination. We can tell our patients that their gynecologic responsibility to themselves consists of two simple parts:

a) First, they should report annually for pelvic examination up to the age of 40 and semi-annually thereafter.

b) Second, they should report immediately the presence of any vaginal bleeding other than normal menstrual bleeding, any change in vaginal discharge, or any unexplained pain.

If the patient fulfills these responsibilities to herself we can offer her real assurance that she will never develop an untreatable pelvic neoplasm.

### The Standard Equipment

Now we come to the doctor's part in the diagnosis of early pelvic malignancy. The physician needs several pieces of standard equipment for successful diagnosis. This equipment cannot be folded neatly into a kit which has been carefully labelled "Cancer Diagnostic Set."



Instead, these items should be kept constantly available and in active office use on all female patients.

The first piece of equipment might be called the "*Cancer Ear*." Our friends, the psychiatrists, are constantly listening with the so-called "third ear" to glean extra information and shades of meaning during their patient interviews. The diagnostician who listens with his "cancer ear" as he takes a history from the female patient may often pick up significant leads to a diagnosis of gynecologic neoplasm. After all, the principal symptoms of gynecologic malignancy are extremely few: they are vaginal bleeding, vaginal discharge, and the sensation of a mass. These three—bleeding, discharge, and a mass—are the presenting symptoms in probably 90 percent of female pelvic malignancies. The unusual symptoms—pain, pruritus, bladder and bowel symptomatology—challenge the physician to elicit other gynecologic symptoms, and to carry his investigation as far as may be necessary for an adequate explanation of such symptoms. The first requirement, then, is a *cancer ear*, and *time to listen*.

The second piece of necessary equipment is a good *light and time to look*. There is no such thing as a "typical" appearance of an early malignancy of the vulva, vagina, or cervix. Therefore, the examiner looks not for cancer, but for lesions; and he looks upon all lesions with suspicion.

The next item of standard equipment is the *bivalve speculum and a willingness to use it*. The use of the speculum has been an acknowledged part of the pelvic examination for nearly a hundred years, but the incidence of its "unemployment" remains distressingly high. It is certainly of more than passing interest to visualize the cervix, where arises more malignancy than in any other area of comparable size in the female, and it takes the speculum to do it.

*Biopsy forceps and knowledge of what to biopsy* form the next item on the list. The practitioner cannot diagnose early cervical cancer by inspection alone. The man who specializes in gynecology cannot diagnose early cervical cancer by inspection alone. Only one man can make such a diagnosis certain; he is the pathologist who has been furnished a tissue biopsy specimen. We have said that there is no "typical" appearance of any early genital malig-

nancy. The factor is made doubly confusing when dealing with the cervix, because so many cervical lesions are in reality a combination of lesions. Thus, the erosion may coexist with cervicitis, and the lacerated cervix may have a polyp protruding from it. Any of these combination lesions may be harboring an early cervical malignancy. The cervical lesion warrants biopsy as well as treatment. The cytologic study has not yet replaced the biopsy in the field of diagnosis. The cytologic smear has definite value, however. It is especially useful in routine work, where there is nothing visible to biopsy. Such smears are picking up a fair number of preinvasive cervical carcinomas, as well as invasive endocervical and endometrial carcinomas.

The fifth part of the standard diagnostic equipment is the *bimanual pelvic examination*. Pseudomedical quacks have long been noted for their alleged ability to diagnose anything—even pelvic tumors—by looking into the patient's eyes, checking her electrical impulses, and by other esoteric means. The conscientious physician has never become that proficient; he must literally feel his way along. While the finding of uterine enlargement or changes in consistency are not as important as the symptoms of discharge and bleeding in early uterine malignancy, such physical changes in the nonpregnant patient may make us suspicious enough to do a diagnostic curettage. The *solid* adnexal mass of almost any size has a high enough malignant potentiality to warrant removal at laparotomy. The *cystic* mass larger than 8 cm. in diameter needs to be investigated at laparotomy. Cystic masses smaller than 8 cm. in size need simply to be examined at regular intervals to be sure they are not growing rapidly.

The last piece of necessary equipment is simply a *conviction*—a conviction that any symptom or finding which is unexplained by office procedures warrants more extensive investigation. It may lead to cystoscopy and pyelography. It may lead to x-ray studies of the bowel. It may very well lead to a diagnostic curettage or an exploratory laparotomy. Most often it will lead to repeat office visits for repeat examination and repeat biopsy. These are the means by which *early* gynecologic malignancy can be diagnosed. The consistency with which they are employed is reflected directly in

the rising incidence of pelvic malignancy which is diagnosed in early stages.

### The Hurdles

That, then, is the list of standard equipment for diagnosis of early gynecologic malignancy. But before the equipment can be put into operation with unfailing success, the diagnostician needs to get over a series of hurdles. Part of these barriers are put there by the patient, part by the physician, and the rest by the characteristics of the female pelvis.

The first hurdle might be termed "You can't examine me while I'm menstruating." The origin of this quaint myth regarding the bleeding patient is lost in antiquity; but the damage done by this false idea lives on and on. We see each year in our gynecologic tumor clinic a number of malignancies which advanced to incurable stages because the patient had the idea that the presence of any vaginal bleeding precluded any pelvic examination. While these patients wait for the bleeding to stop, their tumors presumably are thriving. We as physicians owe the bleeding patient a complete pelvic examination the first day she reports to the office. Examination may demonstrate that what appears to be "a threatened abortion" or "menopausal bleeding" is actually a cervical malignancy.

The second roadblock could be called "You can't see the forest for the trees." This may be best illustrated by a case which occurred very recently. A patient complained of slight bleeding after urination and after intercourse. At the time of her first consultation she did not have a full vaginal examination because she said she had just started to menstruate. However, a urethral caruncle was discovered and assumed to be the cause of the bleeding. The caruncle was treated surgically. The bleeding continued. Catheterization, cystoscopy and retrograde pyelograms were done to look for the source of the blood. After seven months of such treatment the first pelvic examination was done and a huge bleeding cervical lesion was easily palpated and visualized.

The third hurdle is called "The telephone." It includes the patient who expects the physician to treat her pelvic symptoms and reassure her over the telephone without benefit of any pelvic examination. It also includes the rare

physician who has the foolhardy courage to treat the bleeding menopausal patient for six months entirely by phone, receiving regular phone bulletins from the patient, and phoning out ergot prescriptions with equal regularity. Telephone-treated patients really do not even belong in this discussion of early malignancies, because a few months of telephone treatment automatically advances these patients into the advanced stages of malignancy.

Another hurdle is "the estrogen bottle." This hurdle becomes less important with each passing year, as more and more physicians insist on examining the patient and, if necessary, doing a diagnostic curettage to gain a fuller explanation of so-called menopausal bleeding.

A double hurdle is the fibroid and the polyp. Cervical polyps do not often become malignant, but a very significant percentage of patients with cervical and endometrial carcinomas have a history of cervical polyps. Furthermore, some polypoid structures removed from the cervical canal turn out to be uterine malignancies originating above the cervix. With these facts in mind, an office polypectomy becomes a dangerously inadequate diagnostic procedure. The polypectomy should be accompanied by cold knife conization of the cervix and diagnostic curettage. The fibroid, too, is an often misinterpreted structure. The mere finding of apparent fibroids at pelvic examination does not adequately explain irregular vaginal bleeding. Furthermore, the fibroid is almost never the cause of vaginal bleeding in the postmenopausal patient. For these reasons, the bleeding patient with fibroids still needs a diagnostic curettage.

The final hurdle is the symptomatology of the early ovarian malignancy. Perhaps it would be better to call it the absence of symptomatology of early ovarian malignancy. Although the presence of pain and/or a large pelvic mass are the findings most characteristic of ovarian malignancies diagnosed at the Gynecology Clinic of the Ohio State University, the sad fact is that these are not symptoms of early neoplasm. When the tumor has reached football-sized proportions, or when the pain associated with bowel invasion begins, the tumor is no longer an early one. Presumably a large share of ovarian tumors can be arrested if discovered at an early enough stage, and in most instances the discovery must be made before actual symptoms



start. The only possible hope for improving the results in management of ovarian malignancies lies in more frequent examination of the adnexa of more and more women.

We have spent little time in this discussion on the gross description of the various lesions of the vulva, vagina, cervix, tubes and ovaries in early malignancy. There is actually nothing typical about the appearance of the *early* gynecologic malignancy, and we want to be making the diagnosis before the lesions have that "typical look." Neither have we spent time in sorting out the differential diagnosis of the various lesions; if we are conscientious enough to rule out the malignancy first, we can pursue the differential diagnosis at leisure, secure in the knowledge that the process—whatever else it's characteristics—is not an immediate threat to the patient's life. Nor have we stopped to emphasize the usual age range of the different malignancies; we need only remember that almost any cancer can arise at almost any age.

The diagnosis of *late* pelvic malignancy forces itself upon us. We can diagnose almost 100 percent of it, and cure almost none of it. There is no magic key to the diagnosis of *early* malignancy. But on the other hand, the diagnosis of early gynecologic malignancy is not difficult. The details of the performance of the diagnostic procedures are well known to all of us; all we need is the willingness to practice them consistently.

The ultimate hope in the field of gynecologic malignancy lies, of course, in the field of

chemotherapy. Accurate chemical tests for malignancy, infallible antineoplastic drugs, even medications to prevent a malignancy from arising; these are dreams of the future.

The present hope in the field includes not only early diagnosis but also prophylaxis. Several prophylactic possibilities may be mentioned. It has become common practice to do vulvectomy for proven leukoplakia of the vulva, thus helping to reduce the likelihood of later carcinoma of the vulva. Reasonably vigorous treatment of the preinvasive cervical carcinoma is now recognized as excellent preventive medicine. A number of competent gynecologists feel that the prevention and treatment of chronic cervicitis is lowering the incidence of cervical carcinoma. Everyone agrees that the performance of total, rather than subtotal, hysterectomy will remove the problem of the dangerous cervical stump.

### Summary

The program for successful diagnosis of early gynecologic malignancy calls for these things:

First: Biopsy of any vulvar, vaginal, or cervical lesion, especially if it bleeds.

Second: Curettage of any uterus that is producing irregular bleeding, including all postmenopausal bleeders.

Third: Exploratory laparotomy for any solid adnexal mass, or for any cystic adnexal mass which attains a diameter greater than 8 cm.

**49 Million Americans Voted**

**BUT—**

**47 MILLION AMERICANS**

**STAYED HOME!**

**\***

**That's What Happened in the Last Presidential Election**

**\***

**IF YOU WANT A VOICE IN YOUR GOVERNMENT**

**SPEAK UP! — REGISTER! — VOTE!**

# PROLONGED ANTIHISTAMINE ACTION

M. H. MOTHERSILL, M.D.

*Indianapolis*

ALLERGY represents a relatively new classification of medical science. About fifty years ago the word "anaphylaxis" was introduced by Richet, and shortly thereafter von Pirquet coined the term "allergy." In 1910, Dale and Laidlaw<sup>1</sup> made the significant observation that injection of a large dose of histamine produced in laboratory animals many of the symptoms of anaphylactic shock. Later, Best and associates<sup>2</sup> showed that histamine could be extracted from body tissues, and still later Dragstedt and associates<sup>3, 4</sup> showed that release of histamine in the tissues is one of the important causes of allergic and anaphylactic reactions. About seven years ago antihistamine drugs first became available in the pharmacies. These drugs do not lessen the need for careful diagnosis of the allergic patient and identification of the offending allergens followed by avoidance or hyposensitization in so far as possible. The drugs are, nevertheless, very valuable and efforts have been made to synthesize new and more efficient antihistaminic compounds. In the search for better antihistamines, the aim was to discover a drug with longer activity and the ability to exhibit greater symptomatic relief in proportion to undesired by-effects.

## 'Pyronil'

'Pyronil' (Pyrrobutamine, Lilly) is a new antihistaminic which appears to have a number of advantages over other presently available compounds. Pharmacological and clinical results indicate that it is very long acting and can produce desired therapeutic effects with a lower incidence of toxic and side-effects.

Chemically the drug differs from other antihistaminics, as its graphic formula indicates (Figure 1). It is described chemically as 1-p-chlorophenyl-2-phenyl-4-pyrrolidino-2 butene diphosphate.

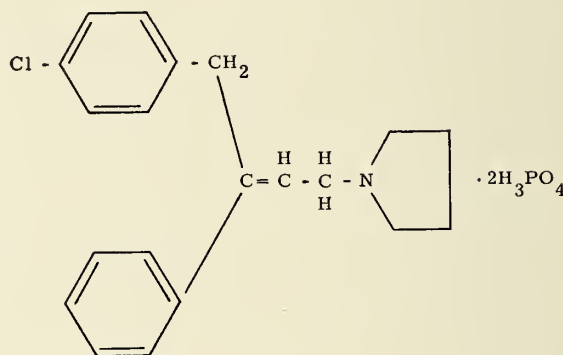


Figure 1.

## Pharmacology

Lee, Anderson, and Harris<sup>5</sup> stated that the diphosphate salt of this antihistaminic base is a white crystalline substance with a melting point of 129.5 to 130° C. It is soluble in warm water to the extent of 10 percent.

'Pyronil' demonstrated an antihistaminic activity of remarkable degree and duration in several different test preparations. Moreover, the ratio of its toxic to its therapeutic doses indicated a very high therapeutic index.

Among the tests carried out was that of protecting guinea pigs in an aerosol of histamine. The guinea pigs were first placed in a chamber through which was passed a histamine aerosol generated at a constant rate from 1 percent solution of histamine acid phosphate. Under these circumstances the animal exhibited within three minutes definite signs of asphyxia. If so, it was removed from the chamber and saved for future tests.

It is known that an adequate oral dose of an antihistaminic compound will protect guinea pigs from the dyspnea produced when they are placed in this histamine aerosol chamber. For example, an oral dose of 'Histadyl' (Thenylpyramine, Lilly) amounting to approximately 5.5 mg. per Kg. was found to protect 50 percent of the animals. The effective dose of 'Pyronil' which



protected 50 percent of the animals ( $ED_{50}$ ) was 0.79 mg. per Kg. In other words, the  $ED_{50}$  of 'Pyronil' was much lower than that of 'Histadyl.'

The effective dose which protected 100 percent of the guinea pigs ( $ED_{100}$ ) was investigated. For 'Histadyl' it was 36.5 mg. per Kg., and for 'Pyronil' 2.75 mg. per Kg. These doses ( $ED_{100}$ ) were then given orally to guinea pigs, and once every hour the animals were placed for three minutes in the histamine aerosol chamber until the effects of the antihistamine drug had worn off. Animals which received 36.5 mg. 'Histadyl' per Kg. were protected for an average of approximately 3.5 hours. Animals which received 2.75 mg. 'Pyronil' per Kg. were protected for an average of approximately 13.3 hours. In other words, a much lower dose of 'Pyronil' protected the animals for a much longer time.

These observations indicate that 'Pyronil' is much more powerful per milligram than 'Histadyl'; but if it were also more toxic per milligram, the figures would lose much of their significance. However, a study of toxicity showed that 'Pyronil' is less toxic. The oral  $LD_{50}$  of 'Pyronil' for guinea pigs was found to be approximately 992.6 mg. per Kg., while that for 'Histadyl' was 374.9 mg. for Kg. In these tests, therefore, 'Pyronil' by mouth in guinea pigs was less toxic per milligram, more potent, and much longer acting.

The therapeutic index is the ratio between the toxic and the therapeutic doses. It may be estimated by dividing the oral  $LD_{50}$  for guinea pigs by the oral  $ED_{50}$  for the same animals in the aerosol experiment. Using this method, Lee *et al.*<sup>5</sup> computed a therapeutic index of 68.2 for 'Histadyl.' This is a wide margin of safety, and it is well known that 'Histadyl' is a safe drug. For 'Pyronil' they arrived at a therapeutic index of 1,272, an extremely wide margin of safety.

Chronic toxicity tests were carried out in rats. The animals were fed diets containing various percentages of 'Pyronil.' Rats whose diets contained 0.1 percent 'Pyronil' ingested an average of 12.99 mg. 'Pyronil' per rat per day. These animals gained weight as rapidly as rats whose diet contained no 'Pyronil.' When we consider that a human being is much larger than a rat and that the adult human dose varies from 30 to 90 mg. per day, it will be seen that this dose of 12.99 mg. per day for a rat was

relatively enormous and yet these animals gained weight like the control rats and showed no evidence of pathology. During the four weeks while the rats were receiving the drug, blood counts were made from time to time and no pathological changes resulted. Rats that received higher doses of the drug up to 47.15 mg. per rat per day exhibited impairment of growth but no other discernible pathology.

### Clinical Trials

Preliminary clinical trials were first carried out in 1950 with the hydrochloride of this antihistamine compound (Drug 11745). The hydrochloride is relatively insoluble and some of the patients did not absorb it well. A change was then made to the diphosphate (Drug 14151) and better results were obtained.

Clinical experience showed that the drug had a very long duration of action but that the onset of its effect was slower than that of 'Histadyl.' One patient was taking 30 mg. of 'Pyronil' (Drug 14151) morning and night with complete relief from hay fever throughout the entire twenty-four hours. An evening dose was, therefore, omitted and on the following morning the usual symptoms of hay fever had reappeared. This indicated that complete relief had been maintained for more than twelve hours but less than twenty-four. The patient then took the usual 30-mg. dose and noted that relief of symptoms appeared in forty minutes. Other patients reported that relief appeared in sixty to ninety minutes.

'Histadyl' is a short-acting drug with a quick onset of activity. In the treatment of hay fever with 'Histadyl' or with 'Hista-Clopane' (Thenylpyramine and Cyclopentamine, Lilly), relief has often been observed within fifteen to twenty minutes.

In order to provide a preparation which supplied both prompt and prolonged effect, it was decided to use a capsule containing:

'Pyronil' .....	15 mg.
'Histadyl' .....	25 mg.
'Clopane Hydrochloride' (Cyclopentamine Hydrochloride, Lilly)	
.....	12.5 mg.

This combination is designated as 'Co-Pyronil' (Pyrrobutamine Compound, Lilly).

Both 'Pyronil' and 'Co-Pyronil' were used in clinical trials during the ragweed hay fever

season of 1951. It happened that in Indianapolis the pollen counts were considerably higher than for many years previously. Counts in excess of 1,000 were reported on a number of days. As a result of this unusually high pollen concentration, many patients did not obtain satisfactory relief with doses of antihistamine drugs which had been successful in previous years. Consequently they were willing to try the new compound.

The dosage directions were:

*Minimum dose:* the equivalent of 1 tablet of 'Pyronil' or 1 pulvule of 'Co-Pyronil' every twelve hours.

*Maximum dose:* the equivalent of 2 tablets of 'Pyronil' or 2 pulvules of 'Co-Pyronil' every eight hours.

Two variables affect the results of a given dose of an antihistamine drug. They are: (1) the degree of sensitivity of the patient, and (2) the amount of exposure to the allergen. Each ragweed-hay-fever patient seemed to have a threshold pollen count at which symptoms appeared. Some had symptoms when the pollen count was only 3 to 5 grains per cubic yard. In others, the threshold was a count of 20, but in the majority the threshold was approximately 100. The difference between the threshold and the actual pollen count was a rough measure of the severity of symptoms.

In a mild case of hay fever under a moderate pollen count, the relief from a given dose of an antihistamine drug may be complete or almost complete and may last for a relatively long time. With a very high count, the same patient on the same dose of the same drug may obtain less relief and the relief will be of shorter duration.

Ragweed-pollen-sensitive patients in Indianapolis who were treated with 'Pyronil' or 'Co-Pyronil' during the ragweed season of 1951 reported varying degrees and duration of relief. Some observed complete or almost complete relief for twenty-four hours or more on a single dose of only 15 mg. Others on a dose of 30 mg. reported relief lasting only four hours. However, these latter patients in the presence of the high counts that prevailed were unable to obtain even that much relief on other antihistamine drugs which they had tried. In other cities (such as New York City) where the pollen counts were much lower, a dose of 15

mg. 'Pyronil' once or sometimes twice daily was often adequate.

Since the Indianapolis group put the drug to a very severe test, a review of the observations is in order.

Of twenty-eight patients who took either 'Pyronil' or 'Co-Pyronil,'

- 15 had highly satisfactory results;
- 8 had satisfactory results;
- 1 had good results but preferred 'Histadyl' with Ephedrine;
- 2 had side-effects on the first dose and discontinued treatment;
- 2 reported unsatisfactory results.

Of the twenty-three patients who reported satisfactory or better results, nineteen recorded the actual dose which they took. It will be recalled that they were given a sliding scale of dosage varying from two to six capsules daily and were told to find the dose between these limits which was most satisfactory under the severest conditions. Some took a single dose of one capsule and waited until hay fever symptoms returned. On days when the pollen count was low they had no symptoms for twenty-four hours. However, the doses which they found best under severe conditions were as follows:

PATIENTS ON 'PYRONIL'

Dose	Number of Patients On This Dose	Side-Effects
2 tablets daily	5	none
3 tablets daily	1	none
4 tablets daily	2	1 had nausea
5 tablets daily	1	drowsiness
6 tablets daily	2	1 reported "tiredness"
		1 reported dryness of nose

PATIENTS ON 'CO-PYRONIL'

Dose	Number of Patients On This Dose	Side-Effects
2 pulvules daily	2	none
3 pulvules daily	4	1 restlessness
6 pulvules daily	1	none
8 pulvules daily	1	occasional nausea and headache

It will be noted that of nineteen patients a total of seven patients obtained good to excellent results on one tablet or capsule morning and night and that none of these had side-effects. On higher doses of 'Pyronil' two gave evidence of sedation, and on 'Co-Pyronil' one reported restlessness. The report of dry nose was not a



serious complaint, and actually this patient was exceedingly well pleased with the results. The patient who took eight capsules of 'Co-Pyronil' daily had some nausea and headache but was also highly pleased with the results of this treatment.

One of the patients who obtained good results on three capsules of 'Co-Pyronil' daily gave the report that follows. It is reproduced in the patient's words.

#### REPORT ON USE OF 'CO-PYRONIL'

"Aug. 30 8:30 a.m. 1 capsule  
Felt almost immediate effect of head clearing; a little dazed and removed feeling, not unpleasant. Nerves soothed.

8:30 p.m. 1 capsule (Had noticed a slight wearing off around 6 p.m.). Slept with no discomfort. Slight dizziness induced by first capsule disappeared.

Aug. 31 8:30 a.m. 1 capsule  
8:30 p.m. 2 capsules  
Seemed to do better with 2 capsules because of heavy pollen count and degree of irritation.

Sept. 1 8:30 a.m. 1 capsule  
8:30 p.m. 1 capsule

Sept. 2 8:30 a.m. 1 capsule  
8:30 p.m. 1 capsule

Sept. 3 8:30 a.m. 1 capsule  
8:30 p.m. 2 capsules  
A slight sneezing attack in the night, but not nearly as severe as usual.

Sept. 4 8:30 a.m. 1 capsule  
8:30 p.m. 1 capsule

Sept. 5 8:30 a.m. 1 capsule  
Skipped capsule at night. Uncomfortable by morning.

Sept. 6 8:45 a.m. 1 capsule—Quick relief.  
12:30 p.m. 1 capsule  
8:30 p.m. 1 capsule—Hard to hold hay fever irritation down.

Sept. 7 8:30 a.m. 1 capsule  
8:30 p.m. 1 capsule

Sept. 8 8:30 a.m. 1 capsule  
8:30 p.m. 2 capsules  
Activity in yard and downtown, nose itching and running, relieved by heavier dosage.

Sept. 9 Skipped a.m. dosage  
8:30 p.m. 1 capsule

"Since this time I have consistently followed the pattern of 1 capsule in the morning and one twelve hours later. I have been more comfortable this fall than I can ever remember being before.

My head has been clear, nasal passages free from congestion and eyes non-irritated. A few times before the 12-hour period was up I felt a little of the usual hay fever symptoms, but they were (with one exception) of insufficient severity to cause me to take a capsule before the twelve hour period of time was up. Once or twice I have awakened and sneezed in the night (5, 6, maybe 8 or more times), but this quickly subsided and I went back to sleep. The capsules seemed to help my digestion because of freedom from allergic irritations."

The period from August 30 to September 9 was characterized by the highest pollen counts in a record-breaking season. The lowest count during this time was 341, the highest was 1,404; and it will be noted that this patient never took more than three capsules of 'Co-Pyronil' on any one day. On a few of the days the relief probably would have been more nearly complete if four capsules had been taken.

The patient mentioned the side-effect of light-headedness only on the first day of use. It has been not uncommon for patients to observe side-effects on the first day and not thereafter. On one occasion the patient skipped the evening dose and symptoms had returned the following morning. Onset of relief was described as "quick" on this occasion and "almost immediate" on another. The promptness of the relief is doubtless attributable to the presence of 'Histadyl' and 'Clopane Hydrochloride.'

#### Conclusion

This and other reports lead us to think that 'Pyroneil' gives better therapeutic effects with a lower degree of side-effects than has been possible before. It also exhibits a long therapeutic effect which makes it convenient to use.

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# PRACTICAL CONSIDERATIONS IN FLUID, ELECTROLYTE, ACID-BASE, AND PROTEIN METABOLISM IN THE SURGICAL PATIENT

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*Hammond*

**D**URING the past quarter century there have been many advances in technical surgery which have extended the advantages of surgical intervention to patients with diseases heretofore considered irreversible. Such has been the progress that no organ or organ system is beyond the reach of some surgeon's attack. Clearly, this is in no way due to the presumption that the surgeon of today has greater personal technical ability than such surgeons of yesterday as Mott, Dupuytren, Kocher and Halsted — for such is not the case. Surely, abundant evidence is at hand in the ever-growing surgical literature that technical advances are consequent upon the fuller appreciation of basic physiologic principles and their practical applications in the care of patients in health and disease. The physiology of the dynamics of circulation and respiration, of the normal constituents of blood, of blood substitutes, of normal and abnormal renal function, and of nutrition in all its phases—all of these things are the foundation of modern surgery. Because knowledge of all these factors with which the trained surgeon of today must be familiar in order to care for not just the diseased organ, but rather for the entire body economy, his work begins much before the patient comes to the operating room and does not cease until long after.

Among the most basic and fundamental considerations in the care of patients is the knowledge of the body's normal maintenance requirements of those substances which constitute his internal environment, and of how they deviate from normal in disease. It is proposed herein to

highlight those deviations and make recommendations for their correction.

## Outline

- I. Normal Dynamics
  - A. Water
  - B. Electrolyte
  - C. Acid-Base
- II. Abnormal Dynamics with Normal Kidneys
  - A. Dehydration
    - 1. Water depletion
    - 2. Salt depletion
  - B. Laboratory procedures
- III. Abnormal Dynamics with Abnormal Kidneys
  - A. Anuria and oliguria
  - B. The postoperative period
- IV. Protein Dynamics
  - A. Normal
  - B. In debility and repair
  - C. Significance of Hypoproteinemia
- V. Recommendations

## Water Balance

The body is composed by weight of 65 percent to 70 percent water. The water is distributed into three compartments:—(1) Intracellular (2) Interstitial and (3) the circulating fluid; the latter two compartments constitute the extracellular fluid. In an average individual of 150 pounds the relative distribution of water would be as in Fig. 1, (from Van Slyke and Evans).

Exogenous intake of fluid and the liquid content of solid food constitute the source of supply of 90 percent of body water. The remaining 10 percent comes from endogenous water of oxidation and the shift from chamber to chamber.

Loss of water from the body is by various routes and subserves different functions:—

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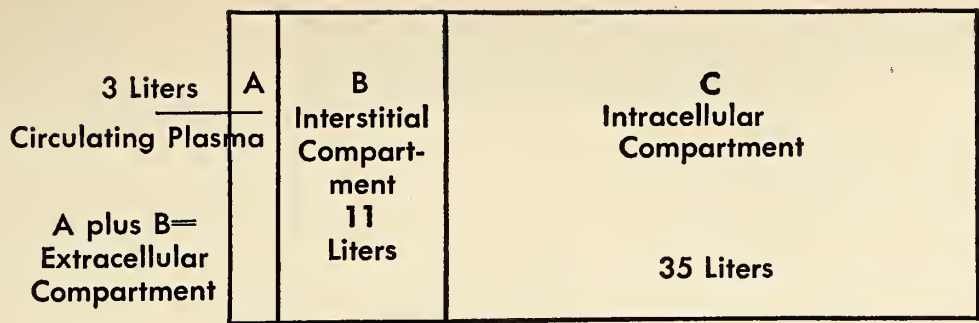


Fig. 1.

1. Loss from the skin subserves the function of dissipation of heat.
  - A. Perspiration, visible—changes readily with availability of supply and with external environment.
  - B. Vaporization, invisible — affected by supply very little. Varies from 1000 to 1500 cc. daily.
2. Urine subserves the function of providing a diluent for the excretable products of metabolism, averaging about 35 grams daily. For this purpose a urinary volume varying between 1000 cc. at a specific gravity of 1.020 to 1500 cc. at a specific gravity of 1.010 is necessary.
3. Lungs vaporize 200 to 500 cc. daily.
4. Stool carries out 100 to 500 cc. daily.
5. An additional amount must be allowed for water loss on the basis of:
  - a. Body temperature elevation which increases visible perspiration.
  - b. Direct fluid loss, measurable, by vomiting, diarrhea, fistulae and gastrointestinal drainage.

**Electrolyte and Acid-Base Balance**

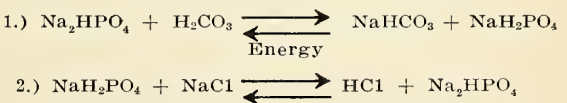
The normal electrolyte pattern consists of a predominance of the sodium ion and the chloride ion. The chloride ion is ubiquitous, whereas the sodium ion is the predominant cation in extracellular fluid and the potassium ion in intracellular fluid. The normal blood and urine findings are as follows:

- Sodium in blood serum—315-340 mgm/100 cc. or 136-145 mEq/liter.
- Potassium in blood serum—16-22 mgm/100 cc. or 3.5-5mEq/L.
- Chloride (as NaCl) in serum — 570-620 mgm/100 cc. or 96-105 mEq/L.
- Sodium in urine—same as blood.

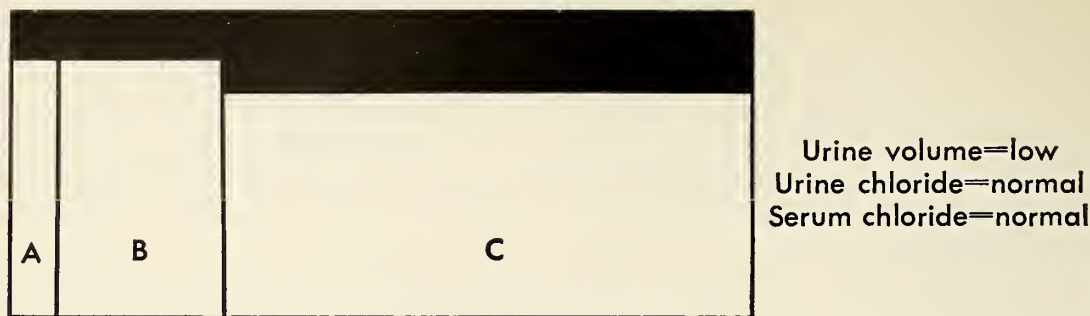
- Potassium in urine—150 mgms/100 cc.
- Chlorides in urine—550-700 mgms/100 cc.

The pH of the blood in health varies very little from 7.45. It is determined mainly by (1) the ratio of the concentrations of the bicarbonate ion,  $\text{HCO}_3^-$ , and of carbonic acid,  $\text{H}_2\text{CO}_3$ , (2) the relative proportions of the biphosphate ion,  $\text{HPO}_4^-$ , and the acid phosphate ion,  $\text{H}_2\text{PO}_4^-$  and (3) by the relative availability of  $\text{Cl}^-$  ions and  $\text{Na}^+$  ions. From the table it is apparent that the blood serum and urine concentrations of sodium and of chloride in health are almost identical. One might assume from this fact that any excess intake of these substances under such conditions would be quantitatively excreted in the urine. Such is found to be the case when the kidneys are functioning perfectly. In depletion of either substance, the deficit would be retained and the excess then excreted if water is made available. Notice that potassium is found in greater concentration in the urine than in the blood; this would suggest that blood potassium is relatively stable and that the urinary excretion of potassium parallels its ingestion. Such is actually found to be the case, in the presence of normal renal function.

In alkalosis the pH of the blood rises. The most common cause of alkalosis is vomiting which results in a loss of chlorides from the stomach. The formation of chlorides in the stomach and its loss may be depicted as follows:



In order for reaction (2) to travel to the right, energy is necessary since the reaction results in formation of a strong acid from its salt. This energy is provided by and is the secretory function of the acid-producing cells of the gas-



**Fig. 2. Water Depletion**

tric mucosa. When the  $\text{HCl}$  is removed by vomiting it is clear to see that there will be an excess of the  $\text{Na}_2\text{HPO}_4$  and the  $\text{NaHCO}_3$ —which constitutes the alkalosis. The treatment of this condition is to supply the deficiency of chlorides as  $\text{NaCl}$ , and the kidneys will excrete the excess  $\text{Na}^+$  as  $\text{NaHCO}_3$ . It has only recently been appreciated that the replacement fluids should contain some  $\text{KCl}$  also, because with every chloride loss there is some concomitant intracellular potassium loss.

In inorganic acidosis there is an excess of chloride due to an excessive loss of sodium. The main clinical causes are (1) diarrheas (2) intestinal fistulae (3) biliary fistulae. The treatment consists in replacement of lost sodium as  $\text{NaHCO}_3$  or preferably as M/6 sodium lactate-Ringer solution.

Acidosis may be organic in nature as a result of the metabolic arrest of carbohydrate oxidation; this is the clinical state of ketosis. The lowering of the pH of the blood is a direct result of the presence of ketone bodies—beta-hydroxybutyric acid, diacetic acid and acetone—which replace the  $\text{HCO}_3^-$  ion. Proper treatment involves the adequate replacement of base and glucose, with provision for more complete oxidation of the latter. If, in addition to the organic acidosis (ketosis) there is water depletion, inorganic alkalosis may be coexistent. If so, treatment requires all four elements—water, base, chlorides and glucose.

#### Dehydration with Normal Kidneys

Consideration of the foregoing factors responsible for normal fluid and electrolyte homeostasis will readily point out the fact that dehydration is not just one thing. Rather, what has been called dehydration falls into two dis-

tinct categories of (1) water depletion and (2) salt depletion. Either of these may exist by itself and the two may coexist.

#### Water Depletion

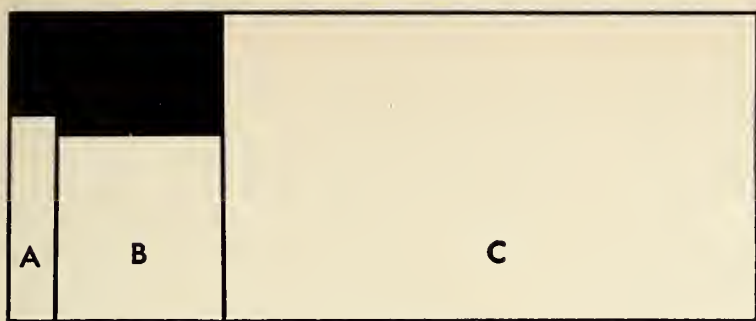
This condition occurs particularly when water is withheld or a deficient amount is ingested. Under such conditions the extracellular compartment becomes temporarily hypertonic. The body adjustments that take place to compensate for this altered state are: (1) water flows from the intracellular compartment to the extracellular compartment, (2) the urinary output is diminished. Thus, there is temporarily a normal serum chloride concentration because of the shrunk intracellular compartment. Diagrammatically we can represent it as shown in Figure 2.

#### Salt Depletion

When there is excessive chloride loss such as in profuse and protracted perspiration and in uncompensated gastrointestinal losses, the extracellular chamber becomes hypotonic. The body adjustments that take place to compensate for this altered state consist essentially in the excretion of excess water without a corresponding amount of salt. This contraction of the extracellular compartment becomes serious because the circulating fluid, a part of the extracellular chamber, is diminished. The diminished circulating volume constitutes shock, acute or chronic, depending on the rapidity of the precipitating loss. Diagrammatically shown in Figure 3.

Thus it is clear that, providing renal function is good, the urine will reflect these changes even before the circulating blood will. In the case of water depletion there will be a diminished urinary output with a normal chloride content.





**Fig. 3. Salt Depletion**

Urine chloride=low  
Serum chloride=low  
when salt depletion is great

In the case of salt depletion there will be an abnormally low urine chloride concentration.

Does a simple urine test exist for the differentiation of these two conditions? Yes—providing the patient has normal kidneys and adrenals. The Fantus test is adequate under such conditions; it is simple to perform and should be available at every nursing division in the hospital. To gain the information desired one must know the urine volume and the concentration of chlorides in the voided specimen. The normal urine chloride concentration is around 550 mgms.% or 5.5 Gms. per liter (approximately the same as blood). With any finding of 3 grams/liter (300 mgm.% or 0.3%) or more one may assume that there is no serious loss of chlorides. Under these circumstances one would start the correction of dehydration with glucose in water or other solutions low in chloride content. If the urine chloride concentration has fallen below 3 grams per liter (less than 0.3%) there is a definite indication for the administration of saline solution. If the urinary chloride concentration is so low that it approaches zero, one must then resort to serum chloride determinations since such very low figures may be a result of renal disease or cardiac decompensation. In patients with such complicating factors operative the use of clinical judgment is called upon—eyeballs, tongue, skin, etc.—in the evaluation of the patient. It must be borne in mind that by the time that one recognizes well established dehydration clinically the patient has already lost at least 6 percent of his body weight. The urinary findings would have detected these deficiencies long before.

The Fantus test is extremely easy and may well be done by the floor nurse. The ingredients are (1) 20 percent potassium chromate, (2) 2.9 percent silver nitrate. One places in a test

tube 10 drops of urine and one drop of the chromate, which is an indicator only. Then one places one drop at a time of the silver nitrate in the tube, which is all the while being agitated, until there is a sudden change from yellow to brick red. The number of drops of silver nitrate used to obtain this change is the number of grams of chloride per liter in the urine; thus 3 drops to bring the change means that the urine chloride figure is 3 grams/liter.

### Potassium Deficiency

Until recent years the importance of potassium loss and replacement has not been appreciated. When there is a great chloride loss, the chloride is accompanied not alone by sodium, but by some of the intracellular potassium as well. In the following states there is an appreciable loss of the potassium ion:—excessive salt depletion, starvation, during the postoperative period when nutrition is by the parenteral route, and most especially when there is bowel obstruction and/or ileus of long standing.

The diminution of normal potassium levels of 4-5 mEq./liter leads to anorexia, lassitude and profound muscular weakness, including myocardial weakness. The improvement in such a postoperative patient on the administration of 2 to 4 grams of KCl is remarkable. It may be given by the gastrointestinal route or parenterally. Electrocardiographically, evidence of hypokassemia or of hyperpotassemia is readily detected.

### Abnormal Dynamics with Abnormal Kidneys

The presence of diminished renal function not only complicates the patient's fluid and electrolyte control by the doctor, but constitutes a complication which is a threat to the patient's life

and demands therapeutic considerations in its own right. The surgical patient may have renal insufficiency on a prerenal, a renal, or a postrenal basis. The concomitance of diseases such as glomerulonephritis and nephrosclerosis (renal) requires the cooperation of the medical colleague. The essential irreversibility of these diseases will often preclude surgical intervention other than emergent in character. The diminution of renal output on the basis of obstruction in the ureters or as a result of prostatic obstruction (postrenal) demands their immediate correction by the appropriate means. It is the prerenal causes of anuria and/or oliguria—specifically shock—which most interest the surgeon in the struggle for a normal water and salt status. Although probably only partially due to changes in vascular pressures (and partly due to the effect of anesthesia on the kidneys) the postoperative period is a special type of anuria/oliguria. It will be discussed separately.

### **Anuria and/or Oliguria**

Anuria or oliguria may be met clinically following accidental trauma, surgical trauma, or spontaneous bleeding such as encountered in massive gastrointestinal hemorrhage as a result of esophageal varices or peptic disease. It is best considered in its component phases.

**Phase I:**—The period of actual hypotension. Such a state, from whatever cause, must be corrected as soon as possible, and preferably with whole blood. The severity of subsequent renal decompensation, other things equal, will depend on the duration of serious hypotension.

**Phase II:**—This is the period of actual anuria—total absence of urinary excretion, or oliguria—diminished excretion of urine. Here serious errors have been made that sealed the fate of such not-yet-to-be-forsaken patients. These errors have been on the side of overly vigorous treatment by an attempt to force the kidneys to “put-out” by trying to force the filtration pressure into high levels. Under such attempts not a few patients have died cardio-respiratory deaths from an overtaxed heart and water-logged lungs, because the spigot at the bottom of the barrel (the kidneys) would not thus be blown out. The kidneys cannot be thus forced to open up. It is therefore mandatory that during the period of actual anuria/oliguria

fluids be kept at a minimum—an amount equal to the output from the skin and lungs (1500-2000 cc./day). Caution must be exercised against the occurrence of acidosis which, if it is detected by blood studies, must be corrected with bicarbonate or lactate solutions. Caution must also be exercised in the matter of observation of muscular twitching. Although this phenomenon may occur with uremia per se, it may also be due to diminished calcium ion concentration, which can easily be replaced. Also the accumulation of the potassium ion in the blood in renal decompensation should be remembered. “Stay on the dry side” is the proper watchword of this period.

**Phase III:**—This is the period of recovery of kidney function. It is characterized by diuresis which may reach spectacular proportions. The danger in this period is the washing out of too much salt as nature temporarily overswings the pendulum. The excess salt lost in the urine during these two or three days must be replaced, not quantitatively but largely.

**Phase IV:**—This period witnesses the gradual recovery of normal renal function as the blood picture shows the daily reduction of azotemia. No specific therapy is necessary.

### **The Postoperative Period**

During the first 24 hours after an operation and sometimes during the first 48 hours, the kidneys are unable to excrete excesses of either water or salts, particularly sodium ion. It behooves the surgeon to stay his hand in ordering too much fluids during this short period. Collier suggested in 1940 that a good postoperative fluid is one containing 0.38 percent NaCl and 0.11 percent bicarbonate. Lichtenstein has suggested that a 0.45 percent saline solution is a better and safer all-around preparation than the so-called normal saline. Some surgeons have come to use intravenous solutions postoperatively that contain no sodium whatever.

### **Protein Dynamics**

#### **A. Normal Dynamics**

The normal total protein value in the serum varies from 6 to 8 grams per 100 cc., and represents a balance between supply, storage and catabolism. Approximately two-thirds of this



amount is the albumin fraction and one-third is the globulin fraction. The albumin is much the smaller molecule and is the important factor in maintenance of hydrostatic pressure and therefore in hypoproteinemic edema of tissues. The globulin fraction is dependent upon good liver function and may contain elements of importance immunologically.

### B. Debility and Repair

During periods of increased catabolism circulating proteins are used to rebuild destroyed tissue, and they in turn are replaced by storage proteins. Even when there are no proteins in storage, the protein utilized will be from ingested protein—given an adequate caloric intake. If the caloric intake is not adequate ingested amino acids will be used for conversion to energy. Under such conditions weight loss will be sustained. Thus, there are two conditions when the real body protein reservoir cannot be accurately assessed from the concentration of circulating serum proteins:—(1) in liver disease, when the proteins cannot properly be processed, (2) during periods of an inadequate caloric intake.

#### Causes of Hypoproteinemia

1. Inability or failure to ingest
2. Impaired digestion and/or absorption
  - a. Chronic diarrhea
  - b. Intestinal fistula
  - c. Gastrointestinal siphonage
  - d. Intestinal obstruction, where the intraluminal fluid is just as lost to the body as if it were lost by routes b. or c. above
  - e. Peritonitis, due to the associated ileus
3. Inadequate synthesis—liver disease
4. Increased catabolism
  - a. Fever
  - b. Elevated BMR
5. Increased protein loss
  - a. Ascites
  - b. Nephrotic syndrome
  - c. Trauma, anesthesia and anoxia
  - d. Hemorrhage
  - e. Burns

### C. The Significance of Hypoproteinemia

Pack and Rhoads have shown that the diminution in circulating proteins of even 1 gram

percent is more serious than appears on the surface, particularly in debilitating disease such as carcinoma. In an average weight individual, with 6000 cc. of blood or about 3000 cc. of serum, the reduction of the circulating proteins by 1 gram percent means that only 30 grams have disappeared from the circulation. However, given a normal status to start with, that is, an individual with some protein storage, there will be no diminution in circulating proteins until the stores have been depleted. The above mentioned workers point out that before there is 1 gram lost from the circulating fluid there has been a depletion of 30 grams from the protein stores (liver and muscle). Therefore, since there were 30 grams lost from the circulation, the minimal actual loss of protein is  $30 \times 30$  or 900 grams of protein. These two pounds of protein loss, plus further loss of energy in the process, plus associated water loss, indicate a loss in body weight of 6 to 10 pounds. Careful questioning of the patient with the 1 gram percent deficit of serum proteins will not fail to reveal this weight loss (exception, of course, is the case of water retention such as in cardiac decompensation or sodium retention in associated renal disease).

The distinction of being the most important protein in the body, if it is possible to assess degrees of importance, belongs to the special protein hemoglobin. In the hypoproteinemia of debility there is almost always an associated depletion of hemoglobin proteinate. When protein is replaced in any such combined depletion, the hemoglobin exercises priority; its demands must first be met before the level of circulating proteins will rise. The copper sulfate falling drop test may be used to assess both values approximately, in a patient seen for the first time, or may be used to follow the progress of a patient from hour to hour or from day to day, assuming that hydration is adequate. A serum specific gravity of 1.027 means roughly 7 grams percent of protein and 15 grams of hemoglobin. For each 1 gram percent deficit of protein the specific gravity will fall by 0.0029.

It is always to be remembered it is possible to have hypoproteinemic edema and yet have a normal total serum protein report from the laboratory. This situation obtains when there is, in addition to the decreased albumin concentration, a marked elevation of the globulin concentration

—and is found in multiple myeloma and some forms of hepatic disease.

The necessity for supplying an adequate caloric intake while proteins are being replenished has been alluded to before. Ravdin and Walker have pioneered in emphasizing this all too frequently overlooked essential. By detailed nitrogen metabolism studies they have shown that amino acids supplied parenterally were used largely for energy requirements until sufficient calories were supplied to spare the proteins for their intended anabolic purpose. Parenteral caloric intake must be boosted by the use of glucose, invert sugar, and alcohol. The use of alcohol intravenously has not yet attained the position it merits, even though some of us have used it extensively for a long time. Alcohol postoperatively is an excellent sedative, in addition to its caloric value, when a blood level of 80 mgm. percent is quickly built up. This is accomplished by giving the first 200 cc. of a 5% or 7½% solution in the first 15-20 minutes (150-180 gtts./min.) and then slowing down to 80 gtts./minute.

The advisability of using these adjunctive measures to provide sufficient caloric intake in order not to waste amino acids may be appreciated from a consideration of basic metabolic facts. The resting metabolic requirements of an adult are 25 Calories/Kg./day. For normal activity of rolling around and moving the extremities in bed another 30 percent of that figure must be added. For each one degree of fever another 8 percent of the original figure must be added. In addition, if alcohol is given, another 8 percent must be added for its stimulating effect on the BMR. Thus, for a 70 Kg. individual:

70 x 25 C. ....	1750 C (BMR)
30% of 1750 C. ....	525 C (bed activity)
16% of 1750 C. ....	280 C (2° fever)
8% of 1750 C. ....	140 C (use of alcohol)
<hr/>	
2695 C Total/day	

It is not always necessary to keep the patient from losing any weight, which means that we may not have to supply all 2695 calories to prevent use of amino acids for energy. However, witness how futile it is even to attempt to come close to that figure with the usually employed 2000 cc. of 5 percent and 1000 cc. of 10 percent glucose, which combined supplies 800 calories

(200 grams x 4 C.). With the use of 10 percent invert sugar (dextrose and levulose) and amino acids and alcohol, it is not difficult to supply 1800 to 2000 calories parenterally, daily. By these methods the conversion of an acute hypoproteinemia to a chronic hypoproteinemia with its dire results of edema, diminished wound healing, diminished resistance to infection and further impairment of liver function, can be prevented.

### Summary, Conclusions and Recommendations

1. The importance of appreciating the normal dynamics of the body's internal environment in the care of surgical patients is emphasized.
2. Water depletion and salt depletion are differentiated; acidosis and alkalosis are traced pathogenetically. The proper fluids and electrolytes for the correction of these conditions are suggested.
3. The importance of the assumption of normal renal function in the interpretation of laboratory data is brought out.
4. The importance of keeping patients with anuria or oliguria and patients in the postoperative period "on the dry side" in order not to overload the vascular system is emphasized. Reasons are given.
5. The significance of hypopotassemia in the surgical patient and its correction is discussed.
6. Protein metabolism in health and in disease is discussed. The causes and results of hypoproteinemia are developed. Specific recommendations for its prevention and correction are detailed.
7. Modern surgery is based on physiologic principles. Intelligent use of parenteral alimentation in the surgical patient demands the understanding and application of these basic concepts.

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## SUN GLASSES

With summer-time now here with its increased glare from bright sunlight, the following little article from *Philadelphia Medicine*, February 9, 1952, is of considerable interest. Doctors drive a great deal, both day and night and should benefit from a perusal of the following:

Dr. Robert H. Peckham, Temple University Medical School associate professor in research ophthalmology, has revealed that the use of sun glasses to protect the eyes from the glare of the sunlight, serves as a help in nighttime auto driving.

Dr. Peckham recently delivered a paper before the Highway Research Board of the National Research Council in Washington, D. C., in which he stated that in a series of rigid tests among 24 drivers near Phoenix, Ariz., where sunlight is particularly strong, drivers

exposed to sunlight during the day and who fail to protect their eyes against sun glare may require nearly twice as much light in night driving as usual to normally see with their headlights.

On the other hand, drivers who filtered the strong sunlight through sun glasses had much better vision during night driving. The tests showed that a driver who protected his eyes against sun glare during the daytime could see an obstacle and stop in time at a speed of 60 miles an hour, while a driver exposed to sunlight during the daytime could not make a safe stop at more than 40 miles an hour.

Dr. Peckham has been doing research concerned with the effect of sunglasses in protecting retinal sensitivity for the last ten years and in that time has worked on the problem for the armed forces, particularly the U. S. Air Force.

**Nobody's too busy to REGISTER  
Nobody's too busy to VOTE!**

\*

**DON'T NEGLECT YOUR PRACTICE IN CITIZENSHIP!**

# A REVIEW OF THE DIAGNOSTIC CRITERIA OF RUPTURED ECTOPIC PREGNANCY

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**A**LTHOUGH it is generally accepted that there is no true pathognomonic picture of a ruptured ectopic pregnancy, nevertheless there are certain subjective and objective findings which are so consistent in their association with this catastrophe that whenever they are present such a diagnosis is justifiable.

Since the significant pathologic sequel to a rupture is bleeding, with the extravasated blood collecting in the pelvic cavity, the characteristics of the clinical picture will be those of circulatory incompetence or failure, and of irritation to the pelvic peritoneum and viscera. The severity of these will vary, of course, with the acuteness of the blood loss.

Every case, therefore, of ruptured ectopic pregnancy of clinical importance will develop and exhibit to a greater or lesser extent symptoms and signs of a progressive anemia, of a growing pelvic mass, and of peritoneal, bladder and rectal irritation.

If then, in addition to the above findings, there is obtained a menstrual history that is suggestive or suspicious because of a recent abnormality, the criteria for entertaining the diagnosis have been satisfied.

Although an equivocal menstrual history might confuse the diagnosis, the management indicated should seldom be long in doubt, when there is enough clinical evidence to suggest the presence of free blood in the pelvic cavity.

A brief summary of six cases is presented below.

## CASE No. 1

Nullipara, Age 18. Hospitalized 1-30-50.

### Admitting Diagnosis:

Probable ruptured ectopic pregnancy.

### Summary of History:

Sudden sharp pain in the right lower quadrant, followed by crampy pains involving the entire lower abdomen. Patient complained of frequency of urina-

tion and strangury. She had a continuous urge to defecate without result. She felt weak and dizzy. She fainted at home while on the toilet.

Patient had missed her last menstrual period.

### Summary of Physical Findings:

Pallor of conjunctivae.

Tenderness of abdomen on palpation. Fluid dullness percussed below the umbilicus.

### Summary of Laboratory Reports:

On admission: R.B.C. 3,250,000; W.B.C. 17,500; Hgb. 59%

After 12 hours: R.B.C. 2,500,000; W.B.C. 19,000; Hgb. 43%

Laparotomy done 12 hours after admission confirmed the diagnosis. A ruptured right tube was removed.

## CASE No. 2

Multipara. Age 26. Hospitalized 8-30-50.

### Admitting Diagnosis:

Probable ruptured ectopic pregnancy.

### Summary of History:

Sudden onset of crampy abdominal pains which began four hours before hospitalization. Urgent desire to evacuate the bladder and bowels frequently, without much success. Dizziness and weakness. Patient fainted on attempting to get out of bed. Patient could not definitely recall whether she had missed her last period or not.

### Summary of Physical Findings:

Patient appeared to be in shock. The pulse was weak and rapid. The systolic pressure was below 80. The abdomen was distended. Palpation revealed tenderness over entire lower abdomen and the probable presence of an indefinite mass. The presence of fluid below the umbilicus was suggested by percussion. Attempts at vaginal examination were unsuccessful.

### Summary of Laboratory Reports:

On admission: R.B.C. 3,350,000; W.B.C. 17,550; Hgb. 59%

After 4 hours: R.B.C. 2,700,000; W.B.C. 17,700; Hgb. 45%

Transfusions were started. Patient was taken to surgery. A ruptured right tube was removed.

## CASE No. 3

Multipara. Age 29. Hospitalized Sept. 7, 1950.

### Admitting Diagnosis:

Acute parametritis.



**Summary of History:**

Patient had been ailing for over one month. At the onset of her illness, her condition was diagnosed by another physician as incomplete abortion. She was treated by curetting the uterus. Following her discharge from the hospital, the symptoms not only persisted, but became worse. In addition, she began to suffer from attacks of chilliness. In spite of the fact that it was summer, she had to remain under blankets most of the time. She had become so weak that she could not walk unassisted. She also had intermittent vaginal bleeding since the curetting.

**Summary of Symptoms and Signs:**

Continual crampy pains of the abdomen, backaches, frequency of urination with strangury. Constipation, dizziness, headaches, weakness. Patient's skin had an anemic pallor. The extremities were cold to touch. The pulse was weak. The abdomen was moderately distended and tender to palpation. There was an indefinite mass palpable in the lower abdomen. Percussion revealed an area of dullness below the umbilicus. There was bleeding from the vagina. Manual examination was unsatisfactory because of acute tenderness. Patient's temperature on admission was 102°.

**Summary of Laboratory Reports:**

On Admission: R.B.C. 900,000; W.B.C. 18,000; Hgb. 26%

Patient was transfused.

The following day the hemogram reported: R.B.C. 1,260,000; W.B.C. 12,000; Hgb. 28%.

A gynecologic consultation was obtained and conservative management, transfusions and antibiotics were advised.

During the succeeding 6 days, patient was given daily transfusions preceded by a blood count. At the end of the 6th transfusion, the hemogram reported: R.B.C. 1,690,000; W.B.C. 12,000; Hgb. 30%.

A posterior colpotomy was done and a dead fetus of about two months' gestation was recovered from the cul-de-sac.

A laparotomy done after this showed an abdominal cavity filled with blood and blood clots. A bleeding left tube was excised. Patient had an uneventful recovery.

Later, an examination of the record of patient's previous hospitalization revealed that only decidual cells had been identified in the uterine scrapings obtained from the curettage. Chorionic elements were absent.

**CASE No. 4**

Multipara. Hospitalized 9-18-50.

**Admitting Diagnosis:**

Probable ruptured ectopic pregnancy. Patient's illness began 3 days before hospitalization.

**Summary of Symptoms and Signs:**

Severe crampy abdominal pains, frequency of urination, dizziness and faintness. She had been bleeding intermittently from the vagina since her last menstrual period three weeks before.

Patient appeared to be in a state of shock. The

abdomen was distended. It was tender to palpation. An indefinite mass could be outlined. Percussion indicated the probability of fluid below the umbilicus. Auscultation showed that the bowel sounds were infrequent and weak.

**Summary of Laboratory Reports:**

R.B.C. 1,890,000; W.B.C. 21,000; Hgb. 33%.

Patient was transfused. A laparotomy was done. The abdomen was found to be filled with a large amount of blood and blood clots. A small fetal mass lying free in the pelvis was recovered. A ruptured left tube was removed. Patient had an uneventful recovery.

**CASE No. 5**

Same patient as in Case 4. Hospitalized 7-4-51.

**Admitting Diagnosis:**

Intestinal obstruction.

**Summary of History and Physical Findings:**

Patient had been constipated for three days. She had vomited on several occasions. She had been having severe colicky pains in the abdomen. She had taken several enemas without relief. She had a continuous urge to urinate. She felt weak and dizzy. She admitted having intermittent vaginal bleeding for over two weeks.

Patient appeared to be in a state of collapse. She was sweating profusely. The abdomen was distended. Percussion suggested the possibility of fluid below the umbilicus. Auscultation showed that the bowel sounds were either very weak or absent. Bimanual examination suggested the possibility of a mass in the pelvis.

**Summary of Laboratory Reports:**

R.B.C. 2,190,000; W.B.C. 150,000; Hgb. 43%.

A transfusion was started. Patient was taken to surgery. A bleeding right tube was found and removed.

**Pathological Diagnosis:**

Ruptured ectopic pregnancy.

**CASE No. 6**

Multipara. Hospitalized 10-11-51.

**Preoperative Diagnosis:**

Acute appendicitis.

**Menstrual History:**

No recent abnormality.

**History and Physical Findings:**

Suggestive of appendicitis.

**Postoperative Diagnosis:**

Ruptured ectopic pregnancy.

Although there is seldom a paucity of symptoms or signs in a ruptured ectopic pregnancy, not infrequently the diagnosis is made only at surgery or at the autopsy table. The reason for this is that all of the symptoms and most of the signs associated with this condition can be caused by other distinct pathogenic entities.

In attempting to evaluate the diagnostic im-

portance of symptoms, due consideration must be made for the emotional pattern which varies from individual to individual, and which forms the background for any subjective expression or response. This becomes especially important when the organs involved belong to a system which because of its peculiar neurohormonal mechanism, is so greatly influenced and controlled by emotional impulses. The extent of this influence is apparent, when it is considered that even purely objective findings as menorrhoea, amenorrhoea and even leukorrhoea can be produced by strong emotional stimuli.

The pain complained of in ruptured ectopic pregnancy may vary in intensity as well as in location, regardless of the site of rupture, even in the same individual, if observation is continued long enough before surgical intervention. Case No. 3 above (which on retrospective consideration of the history must have had a rupture at least four weeks before the laparotomy was done) had, during the period of observation, intervals of *exacerbation* and subsidence of pains. At times the discomfort was greater on one side than on the other. More frequently the pains were generalized over the entire abdomen.

If it is agreed with McKenzie<sup>1</sup> that abdominal and pelvic viscera are insensitive to stimuli which arouse pains, and with Morley<sup>2</sup> that pains following visceral pathology are but the somatic response to mesenteric and perineal irritation, the inconsistent location of pains following a ruptured ectopic pregnancy can be explained on the basis that if this irritation is caused by the accumulation of blood in the abdomino-pelvic cavity, the shifting nature of this fluid would cause stimulation, first to one area and then to another.

The importance of such urinary symptoms as tenesmus and urgency<sup>3</sup> is discredited by some writers as equivocal. Because of its position in the female pelvis in relation to the generative organs, the bladder becomes readily affected by almost any form of pelvic pathology. The reflection of the peritoneum at the superior surface is responsible for the symptoms of vesical irritation, whenever the peritoneum at this area is inflamed.

The obtaining of a history of amenorrhoea or of recent menstrual irregularities is not essential, although if present it might be important

to the diagnosis. Since it still is not known, beyond a point of reasonable doubt, whether there is any period in the menstrual cycle when fertilization is not possible, it is conceivable that a tubal conception and a rupture could occur between periods.

A history of sudden fainting when associated with amenorrhoea and abdominal pains is often considered in many medical textbooks as highly suggestive of a ruptured ectopic pregnancy, for fainting is frequently a sign of shock following massive blood loss, and is an expression of acute anemia or anoxia of the vital cerebral centers. However, it must not be forgotten that fainting and shock can be induced by strong pain stimuli, such as following a Dietl's crisis, or a twisted ovarian pedicle.

The quantity of blood lost is not the only determining factor as to whether or not fainting occurs. Relatively large amounts of blood can be lost without fainting being evidenced, if the bleeding is gradual and intermittent. In this case, the compensatory mechanism of the system has been able to effect temporarily a readjustment of the metabolic demands of the cerebral vital centers to a physiologic level above the shock point. Such a patient will exhibit all the other gross evidence of a progressive anemia, pallor, dizziness, weakness, dyspnea, and collapse. Such was the picture shown by case No. 3, described above.

Vaginal palpation for the presence in one of the cul-de-sacs of a soft boggy mass—the extruded products of conception—is frequently advised as an important diagnostic procedure.

While it is generally implied that only one such examination is necessary, it is to be questioned whether the true diagnostic value of such a procedure can be appreciated unless physical conditions allow the repeating of this bimanual examination at intervals to determine the presence of a growing tumor mass—evidence of blood accumulating in the pelvic cavity.

However, anyone who has examined a number of these cases must admit that such a procedure, unless done under anesthesia, is frequently difficult, if not impossible to perform satisfactorily.

Aspiration of the posterior cul-de-sac for the presence of blood is urged by some as a very important diagnostic step. However, the re-



sults can be inconclusive if not misleading. The failure to recover blood in the syringe cannot rule out the condition, since, although there might have been massive hemorrhage if the blood has been organized in clots,<sup>4</sup> the aspirating syringe might still fail to give proof of bleeding. Again, the aspiration of blood does not conclusively prove the presence of blood in the cul-de-sac, since the needle could have easily pierced a blood vessel in a retroflexed uterus.

A posterior colpotomy properly done, and findings carefully evaluated, can give information that can be considered as diagnostic.<sup>5</sup> The presence of dark clotted blood in the cul-de-sac is almost pathognomonic, while the recovery of the extruded product of conception is confirmative.

Peritoneoscopy<sup>6</sup> as a general procedure is mentioned, only to be condemned. It is even more formidable than the unnecessary laparotomy that it is supposed to prevent. A high degree of technical skill and much experience is needed to manipulate this instrument successfully, if it is to be transformed from being a deadly weapon into a useful adjunct in the diagnostic armamentarium.

The finding of decidual cells without chorionic villi in uterine scrapings from curettement had, for a long time, been considered as pathognomonic of an ectopic pregnancy.<sup>7, 8</sup> Logic seemed to have justified this conclusion. Deciduation is the typical reaction of the endometrium in pregnancy, regardless of the site of nidation.<sup>9</sup>

According to the generally accepted theory, immediately following conception, there is an increase in the titer of available progesterone. This stimulates the pregravid endometrial cells already sensitized by estrogen to undergo metamorphosis to a decidual pattern. When normal implantation occurs, the trophoblastic cells of the fetal chorion become intimately associated with the endometrial deciduae. These, together, are the precursors of the future placenta. Hence, it was felt that the finding of the one type of cells (decidual) indicating conception, without the other (chorionic) which would have indicated implantation, should suggest beyond doubt an ectopic nidation.

However, under the stern test of experience, it soon became apparent that this was by no

means an infallible sign. Romney, Herlig, and Reid,<sup>10</sup> reviewing all cases of ruptured ectopic pregnancy treated at the Boston Lying-In Hospital and the Free Hospital for Women over a ten-year period, 1938 to 1947 inclusive, in which curettements of the endometrium had also been studied, reported that in only 19 percent of these cases did the endometrium show decidual changes. In 81 percent of these known cases of ruptured ectopic pregnancy the endometrium exhibited the nongravid type of cellular pattern. Other writers<sup>11, 12</sup> have published reports in which the results have been similar.

Many interesting theories have been suggested to explain this discrepancy. Novak<sup>9</sup> suggests that following the death of the fetus there is a disturbance in the progesterone estrogen balance which had been responsible for the decidual formation and this induces a rapid reversal of the endometrium to a normal pregravid pattern.

While the absence of decidual cells<sup>13</sup> does not rule out a pregnancy, their presence is not conclusive proof of conception since the endometrium can also be sensitized to their formation by such conditions as cysts of the corpus luteum and granulosa cell tumors. With a hydatidiform mole and chorionepithelioma deciduation may also be found. It is even conceivable that large doses of progesterone administered over a long period of time may also induce similar endometrial changes.

A study of the six cases presented above showed that while a definite history of amenorrhea was obtained in only one case, four of the others admitted having had intermittent bleeding for several days preceding hospitalization.

Abdominal pain was a common symptom, and its description was fairly consistent. It was seldom definitely localized, although in most of the cases an area over the bladder was pointed out as the site of the greatest discomfort. In nearly every case this pain was associated with the urgent desire to defecate and urinate and frequent trips to the bathroom were made.

In three cases reported enemas were taken in the hope of relief before hospitalization. In one case, No. 5, the patient was admitted with the chief complaint of "locked bowels."

Most of the patients complained also of a continuous backache at the lumbosacral region.

A peculiar and perhaps important feature noted on examination was the almost total absence of intestinal sounds, even when the pain was most severe.

Percussion, when done, frequently revealed fluid dullness below the umbilicus. Abdominal palpation was generally more satisfactory than a bimanual examination, and except in the obese patient an indefinite mass usually could be appreciated. The writer noted that if the palpation was done with the patient sitting up in bed rather than lying down, the relaxation of the recti muscles so obtained allows a pelvic mass to be more readily appreciated. Both vaginal and rectal examination caused pain, the vaginal perhaps more so because of its intimate relationship to a bladder already in a state of irritation.

From a practical standpoint, in any case of a suspected ruptured ectopic pregnancy only one question needs to be satisfactorily answered in order to determine the management indicated, and that is, is there evidence of a progressive abdominal hemorrhage? The answer, even in the doubtful cases, can be obtained in a short time. A steadily falling hemoglobin, along with the palpation of a rapidly growing abdominal mass, would justify such a diagnosis and make intervention mandatory.

That the final diagnosis might be, in many instances, a ruptured graafian follicle, or less frequently a spontaneous rupture of a hematosalpinx, is of no immediate concern to the surgeon and certainly of little interest to the patient. Any attempt at a differentiation between these

conditions before surgery is purely an academic abstraction.

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#### ERRATUM

The name of Dr. C. H. McCaskey, of Indianapolis, was inadvertently omitted from the list of contributors to the Medical Education Foundation Fund which appeared in the July issue.



THE JOURNAL  
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MEASLES IMMUNIZATION

IMMUNITY against measles may be acquired by having the disease, in which case the protection is permanent; or immunity may be conferred temporarily by administering the globulin fraction of blood obtained from a person who has had the disease.

The immunizing principle is contained in the globulin. This is a relatively small fraction of the total plasma, and is removed by fractionating whole blood in the preparation of plasma.

Immune bodies are found in all pooled globulin samples. Donors who have not had measles do not contribute immune bodies, but pooling of the plasma from many donors assures the presence of immune principle in each lot.

As is pointed out in an article by Dr. A. C. Offutt, elsewhere in this issue, immunity of varying degrees may be given children who have been exposed to measles. This immunity has a duration of from 21 to 28 days and is therefore suitable for use only in the case of children who have been definitely exposed. If the patient is exposed again after a 21-day period another dose of globulin is necessary.

Due to the fact that immune globulin confers only a temporary protection, it is sometimes desirable to limit the dose of globulin and produce, not complete temporary protection, but modification of the disease. The child then has measles in an attenuated form and acquires a permanent immunity.

Some pediatricians recommend full temporary protection for patients who have active tuberculosis or rheumatic fever, with a view toward preventing measles entirely; but in all other cases favor the use of doses calculated to modify the disease and allow the development of lifetime immunity.

The dosages employed cannot be calculated absolutely since children vary in the amount of natural immunity which they possess. A dose which modifies the disease in one instance may be preventive in an apparently similar child. This, however, is not an important point, and in most cases the desired type of immunity can be obtained.

While gamma globulin is relatively expensive, its use may prevent complications which are

much more expensive. Globulin may be used for other purposes, but its application in the therapy of measles is, in itself, one of the big dividends which we are obtaining from the fractionation of whole blood.

## ARMY MEDICAL SERVICE

**T**HE Medical Service of the U. S. Army celebrated its 177th anniversary on July 27 just past. It was organized in 1775 by the Continental Congress at the request of General George Washington.

Today it is composed of some 90,000 physicians, nurses and enlisted men and women, and is proud to have created the healthiest combat force in history. During the past year the mortality record for wounded who receive medical treatment has improved over that of the first year of Korean fighting. This in spite of the fact that the recovery rate for the first part of the conflict in 1950 was itself an improvement over World War II.

Much of the credit for the Army's improvements in environmental sanitation and in control of diseases of environmental etiology can be attributed to research work which was carried out prior to and during the initial phases of the campaign in Korea.

New drugs, both for the suppression and treatment of malaria, have been developed. A new insecticide was found to control the Korean louse which was highly resistant to DDT. Similar advances have been made in the rehabilitation of the injured and wounded.

Since World War II continuation of a high level of professional attainment has been accomplished by a system of resident training, by the widespread use of civilian consultants, and by the encouragement of professional clinical careers on the part of medical officers.

Medical research is continuing for such problems as cold injury, plasma substitutes, thermal burns and shock.

## INDIANA LEADS STATES IN MONEY RAISED

**T**HE Indiana AMEF Campaign Committee leads all other states in the total money raised for the 1952 drive. To date, the Committee has \$56,511 in pledges and more than 66 per cent of the pledges have been collected.

Dr. James W. Denny of Indianapolis, under whose chairmanship the AMEF drive for funds is being conducted, has asked the physicians of Indiana one simple question that seems to be bringing results. Dr. Denny asks, "Are you one of the 600 Loyal Hoosier physicians that have to date pledged over \$51,000 in our campaign for the American Medical Education Foundation? Or do you belong to the group of nearly 3,800 members that have made no gift? Think it over and decide to which of the above groups you want to belong. Our medical schools need your financial help—NOW—Donations are tax exempt and you are free to choose the school you wish to aid. If you have contributed in 1951, we ask you to repeat in '52—or increase your pledge for this year."

This is a fine example of the work being done at the state level. We hope it will serve as a target for all committees. Let's see who holds the top spot when the next issue of *The Foundation* is published in three months.

*The above news item appeared in a recent issue of AMEF publication "The Foundation." Now is a good time to pile some more on the record breaking total. Let's make it an even better example. Let's make it so big it's hard to beat.*

## PHYSICIANS AND PHOSPHATE INSECTICIDES

**D**URING the last war, the Germans, who had concentrated their efforts on phosphorus-fluorine compounds in their intense search for lethal war gases, discovered that some of these compounds were more effective as insecticides than chemical warfare adjuncts. The compounds tetraethyl pyrophosphate, known as TEPP, hexaethyl tetraphosphate, spoken of as HETP, and



O, O-diethyl O, p-nitrophenyl thiophosphate, designated E-605 by the Germans but now called Parathion in the United States, were uncovered by British and American teams occupying Germany at the close of the war.

During the postwar years, these insecticides were found to be of major importance to agriculture. Of the group, Parathion has been the one most extensively developed in this country. It is now being used by farmers, florists, and commercial spray operators in the form of aerosols, sprays, and dusts. So far its use by home gardeners has been discouraged.

It is highly important that the medical profession realize the widespread use of these phosphate insecticides and be informed of the toxic symptoms they cause in man. Millions of gallons of spray solutions and large quantities of dilute dust containing Parathion were applied for insect and mite control during 1949. Three fatalities and an unknown number of poisonings occurred during last season. All of the fatal cases followed prolonged inhalation of Parathion wettable powder or spray mist and extensive skin contact.

Parathion inactivates the cholinesterase enzymes of the blood and tissues, and, therefore, the signs and symptoms resulting from excessive absorption are primarily those of marked parasympathetic stimulation. The initial complaint is usually giddiness or headache, followed often by abdominal cramps, diarrhea, nausea, weakness, and a sense of contraction in the chest. If the cholinesterase level drops precipitously, marked signs of parasympathetic stimulation will be evidenced by hyperhidrosis, miosis, lacrimation, and salivation.

Many of the parasympathetic symptoms and signs are relieved by atropine. Doses of 1 or 2 mg. per hour up to a daily total of 20 mg. of the drug may be required to control respiratory symptoms and to keep the patient fully atropinized. The intravenous route is best for those severely poisoned. Unfortunately, atropine does not block the muscular weakness. Artificial respiration may be necessary for many hours—clearing of the airways by suction if they are obstructed or positive pressure oxygen if pulmonary edema is present may be lifesaving. Patients severely poisoned can completely recover after full atropinization and artificial

respiration. Morphine should not be given. The acute emergency requiring atropine and artificial respiration may last forty-eight hours.

Physicians in areas where large scale use of phosphate insecticides is prevalent should be on the alert for people who give a history of vertigo followed in two to eight hours by nausea, abdominal cramps, vomiting, diarrhea, muscular twitching, pressure in the chest, convulsions, coma, or pulmonary edema. They may be severely poisoned, and the prompt administration of atropine will block many of the parasympathetic effects.

If a person exhibits toxic symptoms from exposure to the phosphate insecticides, he should be warned against further exposure until restoration of blood and tissue cholinesterase to normal levels has taken place. Because all the phosphate insecticides inactivate cholinesterase, persons exposed to any specific one may be susceptible to any of them for a considerable period of time. Restoration of the cholinesterase level occurs slowly. Laboratory methods are available for the determination of the blood level of cholinesterase. Physicians would do well to advise their patients not to expose themselves further to the phosphate insecticides until the cholinesterase of the blood has returned to normal.

The medical profession has a great responsibility to agricultural personnel who will be using these insecticides this year—alertness on the part of physicians and hospital employees will undoubtedly cut the toll of those who would otherwise die through their own carelessness.

*(Editor's Note:* This editorial is again being printed because the expanded use of Parathion has called attention to the need for caution on the part of field workers. More reports are coming to the attention of entomologists that the insidious lowering of serum cholinesterase is occurring among the workers of field crops and orchards from the careless use of phosphate insecticides.

Atropine can be life-saving and should be given promptly if symptoms appear. The serum cholinesterase level should approach normal before re-exposure to this class of insecticides is permitted.)

—*New York State Journal of Medicine*

## TELEPHONE SOLICITATION

*A*MONG the many telephone calls which doctors receive there is one type, the telephone solicitation for money, which is sometimes difficult to manage. Some of the calls come from legitimate and well-known organizations, and occasion no difficulty because they are well known.

Others originate from unfamiliar sources, and include requests for purchase of advertising space in previously unheard-of newspapers, magazines and bulletins. In campaign years funds are solicited by many political committees other than the official party organizations. In addition there are also many charitable enterprises approaching the doctor with a financial appeal.

The Better Business Bureau advice on this subject is simple and easy to follow. If the solicitee is tempted to donate to a cause with which he is unfamiliar, he should do so only after he has investigated. Information may be obtained from Better Business Bureaus or from the local Chamber of Commerce.

### *Editorial Notes*

The Sullivan County Medical Society met on June 5 to pay tribute to three of its members, each one of whom has completed fifty years of practice.

Carl F. Briggs, M.D., James B. Maple, M.D., and Herbert E. Bland, M.D., were the honor guests at a dinner meeting held at the Sullivan Elks Country Club. Wendell Tennis, prominent Sullivan attorney, gave the testimonial address, and joined with all those present in honoring the three physicians for their long years of community service.

The event was commemorated by the publication of a Year Book which contains biographical sketches of the three doctors and of their colleagues in the Sullivan County Society. I. H. Scott, M.D., was toastmaster and J. T. Oliphant, M.D., made the presentations.

In the organization of the 1952 annual session of the Indiana State Medical Association the Instructional Course Program has been scheduled for Tuesday, October 28, 1952. The Instructional Course Committee has the program well advanced. Thirty courses will again be offered. The first course will be at 11:00 A.M. The remaining courses will be at one, two, three and four o'clock of that afternoon. Each class will again be limited to thirty students admitted by ticket. A schedule of the curriculum accompanied by a blank for the request of advance reservations will appear in *THE JOURNAL* for September and October. Advance reservation has always been heavy and many of the courses are completely filled with thirty reservations immediately after the first publication of the schedule. It is urged that your plans to attend the session of the Indiana State Medical Association be made early and that you be prepared to send your reservation for Instructional Courses immediately upon receipt of the September *JOURNAL*.

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Charles F. Menninger, M.D., founder of the Menninger Clinic, observed his 90th birthday recently in Topeka, Kansas. A native of Tell City, Indiana, where he was born July 11, 1862, Doctor Menninger obtained his college education at Central Normal College in Danville, Indiana. He founded his clinic in Topeka in 1919 and later re-organized it as the Menninger Foundation in 1941. Two of his sons, Dr. Karl and Dr. William C. Menninger, are now active heads of the foundation. Dr. Charles Menninger is active in administrative affairs and serves as chairman of the Board of Trustees.

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The American Heart Association has established an award to encourage high standards of medical reporting in the field of heart and blood vessel diseases. Known as the Howard W. Blakeslee Award, it will honor Mr. Blakeslee, who died recently of heart disease, and who during his life was an outstanding science writer. The award will be presented annually to the individual whose creative efforts in any medium of mass communication contribute most to public understanding of the cardiovascular diseases.



## President's Page

ON JUNE 20th I was invited to address a gathering of the executives and personnel of Blue Cross-Blue Shield at French Lick. I felt honored, inasmuch as it was the first time the State Medical Association had participated in such a meeting, and as I am one who contributed my little "two bits" to get Blue Shield started I was anxious to learn how it had developed.

Blue Shield is an insurance company, just as any company which accepts premiums to indemnify an individual against illnesses. The only difference is that Blue Shield was organized by doctors and is a not-for-profit organization. The schedule of fees was established by the doctors themselves. This does not necessarily mean that the fee permitted under the schedule would completely cover the surgeon's charge. However, there are no doubt circumstances where the individual is unable to pay any additional amount and would be listed as an indigent if it were not for the insurance. Therefore, it should be the policy of doctors to adjust their fees accordingly for the sake of humanity and good public relations. I personally have had employers state that such a procedure should be in order. The fees allowed by Blue Shield are more liberal than most any other company and occasionally it might be good practice to accept them in full payment for services rendered.

The growth of Blue Shield has been most encouraging and has proved beyond a doubt that private enterprise can handle the insurance business more satisfactorily than government agencies.

It should be remembered that in the beginning a great deal of thought was given as to whether Blue Shield should be on the basis of an indemnity or service plan. The opinion of the majority favored the indemnity plan as most equitable and therefore it was adopted.

It should be remembered also that the patient pays the premium and therefore is indemnified for the amount listed in the schedule, and while Blue Shield protects the doctor by making checks payable to patient and doctor, that by no means entitles the doctor to charge a fee greater than average in a given locality. Some abuses have been reported and, if true, cast an unfavorable impression on the entire profession.

If we are to successfully combat socialized medicine, the prime reason for organizing Blue Shield, we can do it better by our own activities and practices. Our insurance companies are our friends and, while we do not wish to discriminate against any one company, we certainly should feel more friendly toward our own "baby" and do everything to protect its good name and ours.

I believe our Blue Shield personnel are sincere and are doing a good job, and should be given a pat on the back instead of a kick.

*William Wright*

# Medical Panorama *by the* ASSOCIATE EDITOR

## HAMMURABI—DIOCLETIAN—AND UNCLE SAM?

On April 27, 1952, at Los Angeles, the new president of the California Medical Association, Lewis A. Alesen, M.D., addressed their House of Delegates on "Physicians in Politics—As Good Citizens." This address, as published in *California Medicine* for June, 1952, is so clear and forceful that we cannot refrain from quoting several excerpts. We should like to reprint the entire speech. He begins by noting that "the physician is trained always to observe and respect the law of cause and effect," then comments on how the "social planners of our era . . . insist on ignoring and breaking the law of cause and effect." And from there—

Let's examine briefly the economics of the world we live in from the viewpoint of the biologist. The biologist, whose job it is to study living organisms, never ignores the law of cause and effect. He deals with things as they are—not as he might imagine or even prefer them to be. Nature, the biologist knows, has one basic, changeless principle. It is the principle of individual responsibility: *individual reward for individual merit and individual penalty for individual failure.*

Nature's unvarying emphasis is upon the individual member of a species. Her sole use of group action is to afford the individual an opportunity for development and to protect him against attack by other species or groups, or by other individuals in the same group. The whole evolutionary process has been directed toward improvement in form and function of the individual.

The dictum of Karl Marx, "*From each according to his ability, unto each according to his need*" when applied "in group action" permits "the individual to diffuse, deny and evade his personal responsibility by merging it with that of the group or state. Such avoidance of personal responsibility exists nowhere in Nature's plan . . ." and the "biologist would expect such conduct in human society to fail." Examples of such failure in ancient times are cited:

In 2285 B.C., Hammurabi, the Babylonian, imposed upon his people the most elaborate set of codes covering every conceivable economic and social activity. The experiment was short-lived. It did not produce a stable society, nor did it encourage production and distribution.

The Roman Emperor Diocletian, in 301 A.D., put the government into every phase of the citizen's existence and thereby so weakened the Roman Empire that it fell a ready prey to invasion just a few generations later.

In 1058 A.D., in China, the emperor of the Sung Dynasty was faced with economic and political difficulties. There were present all the symptoms of a maladjusted economy which inspire our modern intelligentsia to reckless surgery on the body politic. There were over-production and under-consumption, improper distribution of wealth, privilege in high places, economic royalists, and *two-thirds* of the nation were *ill-fed, ill-clothed and ill-housed*. The emperor called in the number-one brain truster, a man named Wang-an-shih, who put into effect sweeping New Deal reforms. Prices, wages and hours were fixed, crop quotas were established, excess crops and animals were destroyed, the ever-normal granary was established, and the currency was devalued. Naturally, the physicians were placed under government control. *Do these tactics sound familiar?* And the results: The experiment lasted for about ten years, at the end of which time Wang-an-shih was forced to flee the country to save his life.

\* \* \*

The philosopher Herbert Spencer taught that the legitimate functions of government are four in number: one, enforcement of the fulfilment of contract; two, punishment of fraud; three, provision of justice; and, four, protection against foreign invasion.

Our social planners have brought us a long way from that concept of government today.

\* \* \*

Twenty-one percent of our electric power is generated by public agencies. We have a managed, inconvertible currency; it is illegal for the citizen to have gold. Incentive has been dulled by confiscatory income taxes. Hard work and thrift are no longer enough; the person who would become independent today must search for so-called tax loopholes or acquire "influence" in high places.

Our press has been subjected to censorship by government bureaus. Our Federal Communications Commission rigidly controls much of the spoken word. Just recently, it solemnly proclaimed that only one type of color television will be permitted. Imagine what kind of cars we would be driving today if in 1902 some government bureau had decreed that Henry Ford's planetary transmission would be the only type allowed to develop.

(Continued on page 809)



Doctors belong in politics because our own problem is only part of a bigger, far more important, general problem. We must take an ever-active interest in politics, not as doctors, but as informed citizens.

Fortunately, most of us Americans have not lost our instinctive feeling for freedom; our deep-rooted belief that we count for something as individuals, not just as members of our union, lodge or medical society. Our children are not yet ready to join Hitler-type youth movements.

Most of us, I believe, are gradually waking up to the realization that we have strayed from the right path, and must find our way back to it. The first step in finding our way is for all of us—doctors, farmers, plumbers, lawyers, electricians—good citizens all—to concern ourselves with politics.

It was never more important. Our future, our children's future, the fate of our country depends on it.

There are many things we can tackle but the least we can do is to *vote*. To vote one must be registered. Here's hoping you have performed this minimal duty, and plan still more.

## TWO-EDGED SWORD

Since use of pitocin in medical induction of labor is becoming increasingly common, the case report abstracted and quoted below should be of more than passing interest. It is by J. E. Krettek, M.D., and B. C. Russum, M.D., in *The Journal of the Iowa State Medical Society*, and is entitled "Sudden Death from 'Pituitrin' Shock."

The role of parenterally administered pituitary preparations in producing collapse or sudden death has been well established and numerous such instances have been recorded. The great majority of the cases reported have, however, been associated with various surgical or obstetrical procedures or in combination with general anesthetic agents.

\* \* \*

The case here described is of interest since death occurred prior to any form of manipulation and in the absence of any other medication.

The fatalities due to the pituitary agents have been generally attributed to either anaphylaxis or coronary constriction.

\* \* \*

In the case to be reported the purified oxytocic fraction of the posterior pituitary (pitocin) was the agent responsible for coronary spasm and death. Although this substance has seldom been reported as the cause of such a fatality, Kantor and Klawans obtained

the greatest reaction with such a deproteinized agent in a series of patients tested with various pituitary preparations. They concluded that only the nonbiologic type of oxytocics (ergot derivatives) can be employed with absolute safety. The action of the oxytocic drug is pointed out by Greenhill who summarizes the recent definitive studies of Parsloe and co-workers as follows: "pituitary extract acts on the heart through the vagus nerves by stimulating the cardioinhibitory center and it causes constriction of the coronary arteries and a decrease of cardiac output, with resulting myocardial asphyxia." Since the maximal action of pituitrin develops 30 to 45 minutes after intramuscular injection, frequent repeated doses may produce a cumulative reaction.

### CASE REPORT

*History:* A 32 year old secundigravida was admitted at term on March 22, 1949. Her past medical and surgical history shed no light on the present illness. She had been delivered uneventfully of her first pregnancy in this hospital at term of a living infant 13 years ago. The hospital record for that admission indicates that 1 cc. of pituitrin was given hypodermically at the end of the second stage. Her blood pressure was 120/80. The present pregnancy had been uneventful and physical examination revealed no abnormalities of the cardiovascular or other systems.

Elective medical induction of labor with pitocin was instituted at 11:00 a.m. At 5:00 p.m. after the last of eight hypodermic injections of 1-3 minims (total 16 minims), she complained of headache and shortness of breath. Her skin developed a flushed, mottled appearance, and her lips became cyanotic. She expired about 30 minutes after the initial onset of symptoms in acute circulatory collapse. Postmortem cesarean section failed to save the infant.

At necropsy the anatomic findings revealed acute cardiac ventricular dilatation with ecchymoses along branches of the left coronary artery, over the left side of the interventricular septum and into the papillary muscles of the left ventricle. "Death was due to the specific pressor action of pitocin upon the coronary arteries, producing vasoconstriction and sudden decrease in cardiac output. The vasoconstriction of the coronary vessels was of sufficient duration to cause anoxia in the heart; small coronary branches or capillaries ruptured and there was hemorrhage beneath the epicardium and endocardium."

It is not our intention to advocate abandonment of this drug, but rather to call attention to a fact which is so commonplace in medical practice that its familiarity may breed contempt, namely, that many of our best weapons are two-edged swords in the use of which both skill and alertness are vital.

# MEASLES

A. C. OFFUTT, M.D.\*

*Indianapolis*

**M**EASLES is one of the most easily transmitted of the communicable diseases to which man is heir. So far this year there have been over 7,500 cases of measles reported in this state. This high incidence was to be expected since 1952 is a third or high year of the measles cycle. Susceptibility to the disease is universal except for infants under six months of age. It should be pointed out, however, that these infants are also susceptible if they have not received an immunity from their mother by reason of her having had the disease previously.

As yet medical science has not been able to develop a practical, active vaccine for the production of a long lasting resistance to measles. The use of gamma globulin, however, will produce a temporary resistance by virtue of passive immunization. It goes without saying that to effect temporary resistance, the immune serum globulin must be given at the proper time and in the proper dosage.

The American Red Cross presently has a program of distribution of this gamma globulin. It is a by-product derived from processing blood obtained from volunteer donors enrolled by the Red Cross. It is supplied to The Indiana State Board of Health for release to proper authorities who in turn use it for the production of temporary passive immunity or modification of measles. In any case, the use of gamma globulin in either the prevention or modification of measles rests upon the decision of the physician.

The American Academy of Pediatrics has recently recommended the complete prevention of measles by passive immunization with immune serum globulin in: (1) all infants from six months of age up to three years; (2) all infants under six months of age whose mothers have not had measles; (3) children ill with other diseases, especially tuberculosis and rheu-

matic infection; (4) in institutions where it is necessary to abort an epidemic.

We are all familiar with the fact that in large communities the spread of measles is difficult to prevent. The principal reason that it is so difficult to prevent the spread of measles is because the disease is communicable in the pre-eruptive stage before diagnosis is made and before the disease is suspected. Another factor which should not be ignored is the fact that it is regarded as an inevitable illness of childhood and so unimportant that many cases are not brought to the attention of the physician. Because of these facts, preventive measures are directed principally toward reducing the frequency of complications and deaths. These measures, therefore, are directed specifically toward adequate medical care for every case and the protection of children under three years of age from exposure to the disease. The only permanent protection of which we now know is the immunity secured by having had the disease.

Physicians are frequently asked about the advisability of closing schools during an increased prevalence of measles in a community. There is no evidence to indicate that this is a satisfactory method of checking the spread of the disease. If the schools are kept open and a daily examination of children by a physician or competent nurse is provided, a further step in prevention will be made. In a nonimmune child with symptoms of a cold or a fever, observation should be accomplished until diagnosis can be established.

In conclusion, immune serum globulin should be and is readily available, but its use should be based upon definite indications. It is suggested that its use always be considered in children under three years of age, in children who are poor risks for infectious disease, and in pregnant women.

\* Director, Division of Communicable Disease Control, Indiana State Board of Health.



# THE ROBE OF AESCULAPIUS

ALBERT STUMP\*

*Indianapolis*

Let us not rend the robe of AEsculapius!

"The desire for unity, the wish for peace, the longing for concord, deeply implanted in the human heart have stirred the most powerful emotions of the race, and have been responsible for some of its noblest actions," said Sir William Osler, a great doctor whose name will live in the history of medicine as long as that thrilling history of devotion to the relief of human suffering survives.

For those who delight in language befitting the glory and majesty of humanity's most exalted purposes, we cannot too strongly recommend that the whole of the essay from which this quotation is taken be read. It can be found in "Aequanimitas" Third Edition, at page 429. The title of the essay is "Unity, Peace and Concord."

In unity there is strength. A single fagot is easily broken; it is hard to break a bundle of them at once. These ancient sayings are axiomatic. Wherever a great purpose awaits accomplishment the wisdom of unity of those devoted to that purpose is indispensable.

The obverse of that principle is just as sure. "Divide and conquer," is the guiding principle of the destroyer. What encouragement the enemy has when the defenders divide themselves into separate groups! Rivalry and dissension have no chance in an atmosphere of unity and concord.

Nestor, the oldest and most experienced leader of the Greeks on the fields of Troy, introduced into their council what all regarded as the wisest advice when he opened his plea for unity in these words:

"Alas, what woe to all the Greeks! What joy  
To Troy's proud monarch and the friends of  
Troy,  
That jealous gods commit to stern debate  
The best, the bravest of the Grecian State!"

The Indiana State Medical Association lifts its voice in warning against any possibility that these tumultuous times may divide the medical profession into groups and factions. No brotherhood should be more closely united to carry out the purposes of a profession than the brotherhood of medicine.

All physicians have come up through the same kind of training. The experiences and disciplines that were necessary for any one of them to be transformed from a layman into a physician were the same for all the rest of them. The cause to which any physician is committed is the same cause to which all the rest are committed. That cause is to do the best each can to make it possible that the knowledge of the whole human family should be made efficient and available everywhere to heal, cure and relieve those suffering from injury or deformity or disease of mind or body. The burden rests upon the conscience of the medical profession, as upon the conscience of no one else, to make the highest possible quality of medical care available to every person who needs it.

The American medical profession was not made the efficient instrument for the service of mankind that it is by any one outstanding character or group of characters. To the everlasting credit of mankind, it can be pointed out as the kind of organization that results where human beings voluntarily subject themselves to the discipline of a profession devoted to the service of mankind. Physicians, through their study of medicine and their contacts with pain and death, are lifted up and ennobled to the exalted determination to do their best to assure health and length of life to everybody. So from the individual physicians scattered throughout the country in humble stations as well as in exalted ones—from the "grass roots" as we say today—grew up spontaneously the need and purpose and finally the organization of the American Medical Association. It was the means through which the knowledge of one

\* Attorney for Indiana State Medical Association.

could promptly become the knowledge of all. Through it new discoveries can be put into immediate use wherever needed, and every advancement by one group or community promptly results in the same advances everywhere.

No profession should look with greater pride or singleness of devotion to the symbol of its achievement and its unity than should the American medical profession upon the American Medical Association. That organization is not old at 105 years. It is still in its mighty strength of youth, and its power is increasing every year. To name but a few of its achievements constitutes such a paean as but few, if any, other human organizations could ever deserve.

The American Medical Association standardizes medical education and hospitals. It does not accept a low level and make that the standard. It finds the very highest and lifts medical education and hospitals throughout the nation to that high standard.

It verifies with unswerving truthfulness the composition and claims made for ethical proprietary remedies with the publication of an annual list of such medicines.

It studies without prejudice or favor the claims and reports of quacks and nostrums, and fearlessly reports the truth regarding them and thereby in scores of instances stimulates the police powers of the government into action to protect the suffering and unlearned.

It assembles with untiring energy information on health and publishes that information to the world through every means of communication available.

It stimulates and organizes the public to provide in a spirit of fine independence for its medical and hospital care through the most thrifty and economical plans of voluntary insurance in Blue Cross, Blue Shield, and other organizations.

It traces and follows every old or new scourge of disease or death to its source, and defying the destructive power of the subparticles of an atom—neutrons, positrons, mesons, or by whatever strange new names they may be called—boldly wrestles with them to force them to give up their injurious activities and turn their energies into the service of the human race. With equal temerity its agents plunge into the swamps and jungles, and deep down under the

sea, and high up into the stratosphere, to find the secrets of life and its origin in the hope that their discoveries may be for the healing of the nations.

It recognizes its obligation as an organization of citizens as well as doctors, and, without counting the cost, draws itself into the forefront of the ranks of those who battle to preserve our institutions of freedom against every socialistic threat, whether it pertains directly to the socialization of medicine or to the socialization of other interests of the public. In this work it has been so forthright and determined, that the whole business and economic life of this country became revitalized by the infusion of its heroic spirit.

No plans of such magnitude, nor loaded so heavily with the hopes and purposes of making a better world, can be developed through the fiat of a totalitarian state or the ukase of a despot to the chance genius, so that they will produce such a record. It can be produced only through the freedom of the minds of all. That record was made as a result of the purpose, determination and wisdom of free men, some of whom occupied places where the inspiring applause of an admiring world rang in their ears, and some of whom "in some sequestered vale of life, kept the noiseless tenor of their way,"—but all of whom were proud to claim, and did not renounce, their place in the brotherhood of the profession of medicine.

During the time these tremendous events were shaping the success in America of the effort to lengthen human life, of course there were many arguments. Of course there were many points of disagreement. Of course there were eager advocates who believed the truth had already been found, and became impatient with their brethren who would not accept it but persisted in further study and research. And on the other hand were those who, because they did not understand, refused to become advocates even when study and research had demonstrated that the truth that should be proclaimed had been found. But through all that glorious history of achievement of the American medical profession there was the strong bond of unity that drew all of these contending forces into the field of one organization through which to carry on their activities. No one from the top handed the policies down to the bottom. The policies were made through the consensus of the



members of the county medical societies throughout the United States.

It is thrilling to those who believe in the efficacy of self-government to contemplate the organization of the American Medical Association. The foundations of it are the county medical societies. The members of these societies are the ones who come with healing in their hands to the families along every country highway, or even where there are no highways, to those who dwell in the villages, and in the county seat towns, and on the most obscure streets and alleys; and also to those who live in the finest mansions of our great cities. No one is kept out of the American Medical Association who is a graduate of a medical school qualified to teach the practice of medicine, provided only that he sincerely adheres to the statement of ethics framed by his comrades in the profession.

The county medical societies join together to constitute the state medical associations, and the state medical associations join themselves together to make the American Medical Association. There is no door into membership in the American Medical Association except that one which is opened to the physician by the members of his profession in the county medical society. No delegate, nor officer, nor member of any committee of the American Medical Association, occupies that place except through the approval and recommendation of those in the profession who know him best. He can become a delegate to the state convention only through election by his county society. He can be an officer of the state association only through election by the delegates from all the county societies of his state. He can be a delegate to the American Medical Association only through election by the delegates of his state association, and he can occupy an office in the American Medical Association only through election by the delegates who were elected by the delegates to the state association, who, in turn, were elected by the individual members of the profession in the county societies. No model of self-government could afford more thorough self-government than is found in the organized medical profession of America.

The activities of the American Medical Association do not await the promptings of those who hold the official positions. They spring from the communities served by those who are

the privates of the profession. The highest honors bestowed by the American Medical Association are bestowed upon those who are on the firing line in the fight against disease. The election of "the physician of the year," for whom organized medicine reserves a prominent place in its annual conventions, is not so much a recognition of the one individual elected for that honor. He is regarded rather as a kind of symbol of the devotion, industry and altruism of the profession.

In honoring "the physician of the year" the medical profession moves along the same lines as those which lead nations to build tombs to the unknown soldier; and to endue, with greater sanctity, his last resting place than any other place within the nation's boundary.

The physician, whose efforts in the ordinary rural center, or in the ordinary neighborhood section of the big city, helps to make the blessed community of that place, is in control of the American Medical Association. The officers, the councils, the committees, the employed personnel, are but his agents and servants. Fortunately they have never aspired to be anything else. They have realized the tremendous significance of the idea that whoever desired to be first should be the servant of all.

While the headquarters of the American Medical Association is located at 535 N. Dearborn St., Chicago, Illinois, it is realized by those who work there that that is the place where the servants of the medical profession work, but that the control of the profession's activities is not located there but is located in the offices of the 160,000 physicians who are the masters of those servants.

Out of the wisdom of the 160,000 members of organized medicine in America has developed one of the strongest forces for the perpetuation of the ideals of freedom that any nation could ever boast in the whole history of mankind. Within the scope of the interests of these 160,000 physicians has been room for the astounding achievements of organized American medicine. As times and conditions have changed, new problems have developed, and with those new problems came new solutions and new inspiration for carrying out the solutions. That possibility of growth has not ended. The ambitious programs of the American Medical Association demonstrate that its eyes are not turned toward the

past but toward the future. Though the American Medical Association is 105 years of age it is as far from senility this year as it was in the year of its birth.

Realizing that new occasions teach new duties while time makes ancient good uncouth, the American Medical Association in a world of increasing complexities has organized its activities to meet every situation as it arose and so be not merely abreast of the times but even ahead of the times and thus in the place of leadership. Its publications attest this statement: *The Journal of the American Medical Association* for the profession; *Today's Health* for the public; nine medical journals for the various medical profession, medical schools, libraries and hospitals; and the quarterly *Cumulative Index Medicus*, indexing regularly the content of more than 1,500 medical periodicals—no age ever produced anything to excel that activity to keep medical knowledge modern in every field and make every item of it accessible to mankind. No other profession ever excelled that effort to serve its members.

How excellent and comprehensive has been its division of labor, to the end that no interest of medicine shall be neglected, is manifested in the functions of its councils and bureaus. The bureaus, which have their headquarters in the office of the association, include one devoted to medical economics, one to exhibits, one to medical legislation, one to health education, and one to public relations. The councils, which generally need not have their headquarters in the office of the association, have their special assignments, and function with high efficiency in their special fields. They include a Council on Medical Education and Hospitals, one on Pharmacy and Chemistry, one on Industrial Health, one on Foods and Nutrition, one on Physical Medicine, and one on Medical Service.

Within this structure of organization no subject of interest to the medical profession is omitted. When new problems in some hitherto unoccupied field arise there will be new bureaus and new councils ready to take them up.

The flexibility and maneuverability of the A.M.A. leaves it ready to face with determination and efficiency every emergency. The profession has made its organization comprehensive and has set no limits to its adaptability. No conceivable condition can arise which would

require the co-ordinated efforts of a group of physicians which cannot be provided for within the A.M.A. If the emergency is local the county medical society of the A.M.A. is available. If it is state-wide the state association is available. If it is nation-wide the A.M.A. is available. If it is international the World Medical Association, of which the A.M.A. is a part, is available. Any group of physicians who may espouse a movement that cannot be promoted within this structure of organized medicine or which neglects to use that instrumentality will find that they may unwittingly become the tools of promoters who seek only their own aggrandizement and fear that the regularly organized profession, which is the A.M.A., will not afford them the personal advantages they desire. That this possibility exists is proven by the little whirlwinds of criticism such groups occasionally blow up against the A.M.A.

Of course in an organization where freedom of thought and speech are cherished, and where the members, by the nature of their profession, become accustomed to rely upon their own individual judgments, there will be arguments. The adopted programs will not be precisely what every member of the organization individually wants it to be. But the spirit of unity will bring about a united effort to make the adopted program succeed until those who seek change will find that experience has demonstrated either their error or their wisdom. In the latter event the opponents cease to oppose. In the former event the proponents join with the opponents. And in either event the robe of AEsculapius remains intact. But suppose they are dissatisfied with the voice and activity of the A.M.A., which is the embodiment of the profession as a whole. A small group begins to organize to do and say what A.M.A. refused to do and say. Then the profession as a whole loses some of its strength and power.

Would it not be better for the entire medical profession, that those who seek to stimulate an activity or develop an organization among physicians to operate outside the A.M.A. should stay within it, and lift their voices and exert their powers of advocacy to make what they think should be done or what they think should be spoken, the act or word of the whole profession?

The medical profession preserves a decent regard for its own past. But it is not a petrified



thing. It is still living. Its views change if experience and widening knowledge indicate that they should. Its consciousness is not a stagnant pool but flows as a stream which freshens and purifies itself by its own activities in a constantly changing world. It is never content that—

“\* \* \* former worth stand fast,

But presses forward, persevering to the last,  
From well to better—daily self surpassed.”

Within its structure is opportunity for criticism of its own actions past or present, for advocacy of new undertakings, and for resistance against change.

One need not fear that his voice will not be heard. Observation will demonstrate that one can scarcely advocate anything in a medical meeting within the organized structure of the profession, which will not receive respectful consideration. The speaker will scarcely be able to avoid being made a chairman of a special committee to carry out his idea, or to make further study of it and report back the results. Physicians who are willing to give their thought and time to the advancement of medicine will find organized medicine eager to press them into service, and clothe them with honor and prestige for any good work they may do. The ambitions of physicians can be fulfilled through their activity within organized medicine. For while working there they are accepting that profound wisdom which holds organized medicine together.

There is no good thing which medicine can do, either for itself as a profession, or for the public whom it serves, that cannot be done better through the recognized structure of organized medicine than through any other means.

It costs money and time to keep up any organization. Neither of those two precious commodities the medical profession has available should be diverted to organizing medical activities that do not constitute a part of the entire program of the medical profession as a whole. May every physician recognize that fact,

and recognizing it, consecrate all the time that he has available for the enhancement of his chosen profession, not for the advantage its members might seek for themselves but for the good the profession may confer upon suffering humanity—which is the highest and most satisfying reason for strengthening and making more efficient their profession!

Medicine has never needed any other implementation than what is available through itself as an organized whole. If more than one voice attempts to speak for the profession as a whole, confusion is the inevitable result. Splinter organizations are not merely futile. They are destructive to the main stem from which they split off. When a physician is solicited to join any medical organization his first inquiry should be, Is it supported or sponsored by the A.M.A.? He can be accurately and promptly informed by a postal card carrying his inquiry to the A.M.A.—or to the state medical association. If the answer is “No,” then in the interest of the profession he should not join. If he wants to be active in organizational medical affairs all he needs to do is to volunteer through his county, state, or A.M.A. organization. The harvest is always plentiful and the laborers are always few. There is plenty of work to do.

But even in trying to solidify the ranks of medicine into one organization of strength and prestige, and prevent it from being split up into discordant groups—each proclaiming itself the voice of medicine but none of them in accord with each other—the physician should still be the living example of tolerance, patience and good-will. He should not fail to speak and act “with malice toward none, with charity for all.” So long as physicians remember that a few things are not transient and evanescent, but that they abide, the spirit of unity will not be lost. What are the important things that abide? The answer is “Now abideth faith, hope and charity, but the greatest of these is charity.”

With charity every rent that may be made in the robe of AEsculapius can be repaired.



# REPORT ON 101ST ANNUAL SESSION OF AMA

WENDELL C. STOVER, M.D.\*

*Boonville*

**T**HE 101st annual session of the American Medical Association, held in Chicago in June, was not only one of the largest meetings in the history of the association, but was also one in which some far-reaching decisions were made. Meeting at the Palmer House, with the scientific session and exhibits being held at the Navy Pier in Chicago, 26,000 physicians and guests registered for the meeting.

Millions of Americans participated in the session via radio and television. Two nationwide television broadcasts were made of the convention and a nation-wide radio audience heard the inaugural address of Dr. Louis H. Bauer, as he took office as president of the association.

Taking a militant stand on many domestic and international questions, as well as the normal transaction of business, the session was hailed by many as one of the best in years. Large attendance at the meetings of the House of Delegates and the reference committees denoted great interest in the proceedings, full discussion marked all sessions, which gave the large number of physicians an excellent opportunity to see their association at work.

## Take Action on Domestic Issues

The session was characterized by the great interest and the number of resolutions presented touching upon the domestic affairs of our nation. The most hotly discussed was the resolution presented by Dr. Warren Furey of California, in which condemnation of the President's Commission on Health was asked, as being purely political. During the discussion and packed hearings Doctor Magnuson appeared to defend the Commission and criticized the profession for proposing such action until following the Commission's making their report.

Taking the position that the Commission was formed as a matter of political expediency, the resolution pointed out the following: The forma-

tion of the commission constituted a complete change of strategy on the part of the Administration in Washington, a change of strategy which seemed to be calculated to relieve some of the pressure which had developed as a result of dissatisfaction with Mr. Oscar Ewing's proposals. The timing of this shift is important, since it came during a campaign year. The commission was established as an emergency, under conditions which would prohibit it from continuing to function beyond one year. The Commission was not established by legislative action of the Congress, under which conditions it might have continued long enough to investigate thoroughly all aspects of the problem.

The chairman of the Commission, Doctor Magnuson, informed the reference committee that he knew before accepting the chairmanship the task outlined for the Commission could not be fully and adequately completed in the allotted time. In his testimony before this committee, the chairman stated that he undertook this task as a public service to his country and that this action of his entailed considerable financial sacrifice.

The attitude of the Board of Trustees is best conveyed by quoting from a letter sent to chairman Magnuson under date of February 13, 1952, part of which follows:

"The Board's action in making this information available to the Commission, however, should not be construed as implying approval of the Commission or its projected program, which we believe to be of political intent. The Association's position in opposition to the operation of this Commission has been previously stated and is unchanged."

## Report Delays Action

In making its report, the Reference Committee recommended that final judgment be withheld until President's Commission makes its report this December, and commended the Board of Trustees for the restraint they had exercised regarding some of the statements that have been attributed to the Commission.

\*Delegate from the Indiana State Medical Association to the House of Delegates of the AMA.



### Would Limit Taxation

Another action of the House was the passage of a resolution introduced by Dr. John R. Glen, on behalf of the Texas delegation. The House of Delegates expressed an opinion that taxes are too high and favored passage by Congress of an amendment to the Constitution, limiting the taxing power of the Federal government. The resolution resolved the following:

"Resolved, that the House of Delegates of the American Medical Association go on record as favoring an amendment to the Constitution of the United States limiting the taxing power of the federal government."

### Danger Cited

Pointing out the danger of this nation becoming involved in old world socialism and idealisms through treaty or executive agreement, Dr. Louis H. Bauer submitted a resolution calling for approval of the Association to strongly favor an amendment to the Constitution of the United States which will provide that no treaty or executive agreement shall be made which conflicts with any provision of the Constitution or which operates or may operate to regulate any of the purely domestic affairs of the United States. Calling attention to the action of the International Labor Organization and other agencies Doctor Bauer stated we could become involved in international socialism, without consent of the people, if some control is not placed upon those who make agreements which are binding on us.

### Officers Elected

The House of Delegates elected Dr. Edward J. McCormick of Toledo, Ohio, president-elect. Doctor McCormick is well known in Indiana, as he has spoken here many times. His most recent appearance was during the Conference of County Medical Society Officers on March 2 of this year.

Dr. James F. McVay of Kansas City, Missouri, was named to the Board of Trustees; and Dr. Dwight Murray was re-elected for another term on the Board and was subsequently re-elected its chairman. Dr. Leo F. Schiff, Plattsburg, New York, was elected vice-president; and Dr. J. J. Moore, Chicago, was re-elected treasurer. Dr. James R. Reuling, Bayside, New York, was named speaker of the House to succeed Doctor Borzell who retired; and Dr. E. Vincent Askey, Los Angeles, was named vice-speaker.

### Actions of the House

*Distinguished Service Award* made to Paul Dudley White, M.D., Boston.

*Re-Evaluation of Principles of Medical Ethics*—Council on Constitution and By-laws to study and evaluate the present principles of medical ethics and report back to the House of Delegates its recommendations.

*Resolution on International Labor Organization Attempt to Socialize Medicine*—The attempt to socialize medicine by international convention was condemned by the adoption of this resolution.

*Resolution on Restriction of Membership in the American Medical Association*—Requesting all state and county medical societies, as well as the AMA, to study this problem and work to the end that all men and women professionally qualified shall be eligible for membership in the AMA, regardless of race, color or creed.

*Resolution on Keogh-Reed Bills*—Calling for adoption of these measures and expressing the gratitude of the profession for the work that has been done in attempting to obtain passage of these measures and calling for continued effort on the part of the Board of Trustees through every avenue at their disposal.

*Resolution to Establish Health Commission Within the Association*—This was referred to the Board of Trustees for further study.

*Resolutions on Specialty Board for Microbiology*—Nine resolutions were introduced on this subject, the reference committee recommending that no action be taken pending the making of a report to the House by the Council on Medical Education and Hospitals and the Board of Trustees, pointing out at the same time that the Council on Medical Education and Hospitals has not recommended the approval of an American Board for any nonphysician group.

*Resolution on Armed Forces Dependent's Medical Care*—Calling for providing that medical service might be provided dependents of armed service personnel by physicians on a service basis through the Blue Shield Plan received no action for lack of anyone appearing before the committee to explain the resolution.

*Resolution on Medical and Hospital Benefits to Veterans*—This opposed acceptance of non-service-connected cases as being in direct competition with private physicians. Resolution adopted and referred to special committee of the

Board of Trustees which is currently making a study of Federal Medical Services.

*Resolution Making Section Delegate a Member of the Executive Committee of the Section*—was approved.

*Resolution Calling for Provision of Funds to Defray Expenses of Section Delegates*—Adopting this resolution, the Board of Trustees was instructed to pay transportation and per diem allowance as determined by the Board to the Section Delegates incident to attendance at sessions of the House.

*Resolution of Federally Financed Medical and Hospital Benefits for Dependents of Service Personnel*—opposing use of federal funds to provide this service, the committee approved the resolution but advised that further study was necessary and suggested the special Board of Trustees' committee, presently studying Federal Medical Services, also study this matter.

*Resolution on Transfer of Disabled Veterans*—in which it was requested seriously disabled veterans be transferred from service to veterans hospitals, was approved and pointed out that testimony before the committee indicated this was being done as rapidly as possible.

*Reactivation of Committee on Motor Vehicle Accidents*—It was recommended the matter be referred to the Board of Trustees with the suggestion they contact the various national safety organizations; and if in their judgment such a committee would serve a useful purpose, then the committee should be reactivated.

*Candidates for Public Office*—in which the American Medical Association made its stand clear as not supporting any political party or candidate for elective public office, was adopted.

*Change of Date for Deciding Apportionment of Delegates*—The date was changed from December 1 to December 31 when the AMA will apportion delegates among the various states. Each state will be allowed one delegate for each 1,000 active members or fraction thereof who have paid their dues by December 31 of each year. Should a state have its delegation reduced because of lack of members, the state shall be entitled to let its present duly elected delegates serve out their elected term.

*Internships and Residencies*—This resolution called for the Council on Medical Education and Hospitals to undertake an immediate restudy and re-evaluation of the policy of establishing internships and residencies toward the purpose

of correcting the imbalance existing between the large number available and the small number of physicians available for them. It was adopted.

*Re-evaluation of American Boards*—Asking that the method of classifying services of a hospital in terms of years as announced by the American Boards in 1949 be reconsidered. While approving the intent of the resolution the committee recommended the adoption of a substitute resolution which referred this to the Council on Medical Education and Hospitals for careful study and consideration as to what arrangements if any can be made in this type of training.

*Cooperation Between Medical and Dental Profession*—Objecting to the requirements established by the Board of Oral (Dental) Surgery, the committee recommended the resolution not be adopted, but that the Board of Trustees of the AMA confer with the American Board of Oral Dental Surgery to the end that a clear definition of dental and medical services be established. It also called attention to the fact that only properly qualified physicians may practice medicine.

*Amalgamation of the Osteopathic and Medical Profession*—Urging immediate steps be taken to bring these professions into one group under circumstances which would be acceptable to the Judicial Council, the committee referred this to the Board of Trustees, requesting a special committee be appointed to study this matter and to consult with the American Osteopathic Association if or when requested.

*Medical Care of Veterans*—in which the Veterans Administration is asked to require filing a signed statement of inability to pay for medical care from applicants for VA medical care.

*Limitation of Federal Taxation*—This resolution as adopted called for the AMA taking a stand favoring an amendment to the Constitution of the United States limiting the taxing power of the federal government.

*Disapproval of Certain VA Practices*—The resolution called for disapproval of the practice of the VA accepting non-service-connected cases which were covered by insurance and accepting insurance company fees. Referred to the Board of Trustees' Committee studying Federal Medical Services.

*Emergency Seating of Alternate Delegates*—by which the remaining delegates from a state would have the right to name an alternate delegate to take the place of one absent for some



cause was referred to the Committee on Constitution and By-laws as it would require a change in the Constitution.

*Jurisdiction of Judicial Council*—in which it was suggested the wording be changed to "The Council shall have appellate jurisdiction in question of law, procedure and fact." Referred to the Council on Constitution and By-laws for study, legal review and advice, and is to be reported on at the Interim session.

*Military Credit for Internships in Military Hospitals*—The House approved opposition to any regulation that might be formulated which would have the effect of allowing intern service to count against total military and reserve obligation.

*1955 Annual Session*—Atlantic City was selected for the 1955 Annual Session, and Boston was selected for the 1955 clinical session. Future meetings of the Association will be held at the following locations: 1952 Clinical session, Denver, Colorado; 1953 Annual Session, New York; Clinical session, St. Louis; 1954 Annual Session, San Francisco; Clinical Session, Miami.

### Indiana Represented

Indiana was represented in the House of Delegates by Drs. F. S. Crockett, Lafayette; Homer G. Hamer, Indianapolis; Alfred Ellison, South Bend, and Wendell C. Stover, Boonville. Indiana's alternates also present were Drs. Cleon A. Nafe, Indianapolis; E. S. Jones, Hammond;

Karl R. Ruddell, Indianapolis and Robert H. Rang, Washington.

Four Indiana physicians were honored by being awarded Honorable Mention for their exhibits: Drs. Boynton H. Booth and Roland W. Jones, Indianapolis General Hospital, for their exhibit on Grain Itch; Drs. Harold D. Lynch and William D. Snively, Jr., Evansville, for their exhibit on Hypoproteinosis of Childhood.

Dr. Robert J. Masters, Indianapolis, was appointed chairman of the Section on Ophthalmology's executive committee, and Dr. Lall G. Montgomery, Muncie, was named chairman of the Section on Pathology and Physiology.

Sixteen Indiana physicians participated in the scientific meetings, by either presenting papers or participating in discussion panels. They were as follows: John W. Beeler, M.D., Indianapolis; Raymond C. Beeler, M.D., Indianapolis; Boynton H. Booth, M.D., Indianapolis; Clyde G. Culbertson, M.D., Indianapolis; Herbert S. Gaskill, M.D., Indianapolis; Roland W. Jones, M.D., Indianapolis; Forrest M. Kendall, M.D., Napanee; Robert F. Kimbrough, M.D., Fort Wayne; William R. Kirtley, M.D., Indianapolis; Carl H. McCaskey, M.D., Indianapolis; Lyman R. Pearson, M.D., Indianapolis; Russell A. Sage, M.D., Indianapolis; V. Brown Scott, M.D., Shelbyville; Harris B. Shumacker, Jr., M.D., Indianapolis; John C. Slaughter, Jr., M.D., Evansville; V. K. Stoelting, M.D., Indianapolis.

Those from Indiana who were registered for the Chicago meeting are as follows:

Abreu, Benedict, Indianapolis  
Acker, Robert B., South Bend  
Acos, James C., East Chicago  
Ade, Charles H., Lafayette  
Ade, Mary Keller, Lafayette  
Adler, Ray N., Evansville  
Alexander, John Evan, Evansville  
Allen, H. E., Richmond  
Almquist, C. O. G., Gary  
Alvey, Charles R., Muncie  
Amstutz, H. Clair, Goshen  
Arbogast, J. L., Indianapolis  
Arlook, Theodore D., Elkhart  
Armalavage, Leon J., Gary  
Armington, Robert L., Anderson  
Armstrong, Thomas D., Michigan City  
Ash, Harold N., Lafayette  
Asher, J. W., New Augusta  
Ault, Roy J., Terre Haute  
Austin, Richard Paul, Bedford  
Baitinger, H. M., Gary  
Baker, J. Warren, Michigan City  
Baker, Leslie M., Aurora  
Baker, Mason R., Evansville  
Balkema, Catherine M., Lafayette  
Balla, Morris, South Bend  
Bankoff, M. D., Michigan City  
Baxter, Neal E., Bloomington  
Beam, Vernon B., East Chicago

Bean, Joseph S., Indianapolis  
Beaver, Norman E., Berne  
Bechtold, Samuel E., South Bend  
Beeler, John W., Indianapolis  
Beeler, Raymond C., Indianapolis  
Benchik, Frank A., East Chicago  
Bennett, J. B., Warren  
Bennett, Jene R., South Bend  
Berger, Morley, Beech Grove  
Berghoff, Raymond J., Fort Wayne  
Berke, R., South Bend  
Bethea, Dennis A., Hammond  
Bethea, Robert O., Jr., Farmersburg  
Beverland, M. E., Indianapolis  
Biasini, Benedict A., South Bend  
Bibler, Lester D., Indianapolis  
Bichcoff, Billie Delores, Fort Wayne  
Bickel, David Andrew, South Bend  
Billings, Elmer R., Elkhart  
Bills, R. N., Gary  
Birdzell, John P., Crown Point  
Birmingham, Peter J., South Bend  
Bixler, Louis C., South Bend  
Black, C. S., Warren  
Blum, Leon L., Terre Haute  
Bolka, B. J., South Bend  
Bonaventura, A. P., East Chicago  
Bond, Walter C., Clay City  
Booher, Norman R., Indianapolis

Booher, Olga Bonke, Indianapolis  
Booth, Boynton, Indianapolis  
Borough, L. D., South Bend  
Bowers, J. W., Fort Wayne  
Brady, Samuel, Gary  
Brandman, Harry, Gary  
Brauer, Abraham, East Chicago  
Brayton, John R., Indianapolis  
Brechtli, Harvey J., South Bend  
Briggs, C. F., Sullivan  
Brown, Leo Ralph, Gary  
Brown, Thomas M., Muncie  
Brown, Wendell E., Indianapolis  
Bryan, Franklin A., Fort Wayne  
Bryan, Robert J., South Bend  
Brubaker, Harold S., Huntington  
Bruegge, T. J., Kokomo  
Buchanan, Wallace D., South Bend  
Buckner, Doster, Fort Wayne  
Bullard, Mattie J., Gary  
Bunde, Carl H., Indianapolis  
Burkhardt, B. A., Tipton  
Burney, Leroy E., Indianapolis  
Burnikel, Ray H., Evansville  
Bussard, Frank W., South Bend  
Butterfield, Robert M., Muncie  
Cacia, John Joseph, Evansville  
CaJacob, M. E., Terre Haute  
Callahan, Richard H., East Chicago

Calvert, Raymond R., Lafayette  
 Cameron, Don F., Fort Wayne  
 Campagna, E. A., East Chicago  
 Campbell, Guy Gibson, Munster  
 Campbell, John A., Indianapolis  
 Carlberg, O. L., Jeffersonville  
 Carlson, Norman R., Michigan City  
 Cartwright, Emor L., Fort Wayne  
 Casebeer, Paul Bevan, Clinton  
 Casey, Stanley M., Huntington  
 Cassidy, J. V., South Bend  
 Caylor, Truman E., Bluffton  
 Challman, William B., Mount Vernon  
 Christophel, Verna, Mishawaka  
 Chroniak, Walter, Indianapolis  
 Clark, Stanley A., South Bend  
 Clarke, Elton R., Kokomo  
 Cleveland, John B., Michigan City  
 Clevenger, Joseph H., Muncie  
 Close, Walter Donald, Indianapolis  
 Cole, Ira, Lafayette  
 Cook, G. M., Hammond  
 Crandall, L. A., Jr., Elkhart  
 Crimm, Paul D., Evansville  
 Cring, George V., Portland  
 Crockett, Franklin S., Lafayette  
 Culbertson, Carl S., South Bend  
 Culbertson, Clyde G., Indianapolis  
 Custer, Edward W., South Bend  
 Dalton, John Eric, Indianapolis  
 Dalton, Wilson L., Shelbyville  
 Danielecki, L. J., Gary  
 Dannacher, William D., Wabash  
 Dassell, Paul M., Hammond  
 Davidoff, M. A., Ossian  
 Davis, Alice Hall, Hammond  
 Davis, Carl M., Valparaiso  
 Davis, Joseph B., Marion  
 Davis, Merrill S., Marion  
 Davis, Richard M., Marion  
 Denaut, J. E., Knox  
 Denny, J. W., Indianapolis  
 DeWitt, Charles H., Valparaiso  
 Diamond, Leo L., Marion  
 Dolezal, Bernard J., South Bend  
 Donahue, George R., Lafayette  
 Douglas, George R., Valparaiso  
 Dugan, William M., Indianapolis  
 Edwards, B. E., South Bend  
 Egan, Sherman L., South Bend  
 Egbert, Herbert L., Indianapolis  
 Egnatz, Nicholas, Hammond  
 Eisaman, Jack L., Bluffton  
 Eisenberg, D. A., Martinsville  
 Elliott, J. C., Guilford  
 Elliott, Ralph, Gary  
 Elliott, Thomas A., Elkhart  
 Ellison, Alfred, South Bend  
 Engleman, H. K., Georgetown  
 English, Hubert M., Gary  
 Erickson, Gustaf Walter, South Bend  
 Eviston, J. B., Huntington  
 Faltn, Ladislaus, South Bend  
 Fargher, F. M., Michigan City  
 Feldman, Max, South Bend  
 Ferry, John L., Whiting  
 Ferry, Paul W., Kokomo  
 Fichman, Abraham M., Fort Wayne  
 Fipp, A. L., Rome City  
 Fischer, Burne H., Hammond  
 Fischer, Warren E., Anderson  
 Fish, Edson C., South Bend  
 Fisk, Frank B., Indianapolis  
 Fitzgerald, Maurice D., Evansville  
 Fitzgerald, William J., Indianapolis  
 Fitzsimmons, Elvin L., Evansville  
 Flack, Russell A., Lafayette  
 Flinn, John H., Evansville

Fouts, Paul J., Indianapolis  
 Foy, Hayward, Fort Wayne  
 Frank, John Ray, Valparaiso  
 Frankowski, C. E., Whiting  
 Frasch, M. G., Lafayette  
 Freeman, Floyd M., Goshen  
 Frey, W. B., South Bend  
 Friedman, Morris S., South Bend  
 Frith, Louis G., South Bend  
 Frost, Robert J., Michigan City  
 Galbreth, J. P., Burnettsville  
 Ganser, Richard A., Mishawaka  
 Ganz, Max, Marion  
 Gardner, Russell A., Michigan City  
 Garling, L. C., Muncie  
 Gastineau, F. M., Indianapolis  
 Gatch, W. D., Indianapolis  
 Gates, George E., South Bend  
 Gibson, Greta Maxine, Indianapolis  
 Gingerick, Charles M., Liberty Center  
 Gladstone, N. H., Fort Wayne  
 Glock, Maurice E., Fort Wayne  
 Gossard, Meredith, Tipton  
 Gould, Lyman K., Fort Wayne  
 Grant, Benjamin F., Gary  
 Gray, Leon, Martinsville  
 Grayston, Wallace, Huntington  
 Green, George F., South Bend  
 Green, Norval E., South Bend  
 Griffith, Richard S., Indianapolis  
 Grillo, Donald, South Bend  
 Groman, H., Hammond  
 Gustaitis, John W., East Chicago  
 Hadley, D. David, Indianapolis  
 Hall, James M., South Bend  
 Haller, Thomas C., Crawfordsville  
 Hamer, Homer G., Indianapolis  
 Hamilton, Charles O., South Bend  
 Hamilton, Thomas G., Columbia City  
 Hansen, Arthur H., Hammond  
 Harmon, V. E., South Bend  
 Harris, Paul N., Indianapolis  
 Harshman, M. L., Lafayette  
 Harstad, C., Rockville  
 Hartley, C. A., Jr., Evansville  
 Hasewinkle, A. M., Fort Wayne  
 Hasler, Norman B., Crown Point  
 Hattendorf, A. P., Fort Wayne  
 Haugseth, E. K., South Bend  
 Haymond, J. L., Indianapolis  
 Hedrick, James T., Jr., Gary  
 Herzer, C. C., Evansville  
 Henderson, Francis G., Indianapolis  
 Heritier, C. Jules, Columbia City  
 Hilldrup, Don G., Indianapolis  
 Hochhalter, Marian, Logansport  
 Holdeman, L. S., South Bend  
 Holdeman, R. W., South Bend  
 Holladay, L. J., Lafayette  
 Holloway, William A., Logansport  
 Holman, Jerome E., Jr., Indianapolis  
 Holsinger, Robert E., Indianapolis  
 Honan, Paul R., Lebanon  
 Horst, William N., Crown Point  
 Horwitz, Thomas, Indianapolis  
 Hostetter, Irwin S., Muncie  
 Houston, Fred D., Lawrenceburg  
 Howard, W. Harry, Hammond  
 Huffman, V. Park, South Whitley  
 Hughes, Richard R., Lafayette  
 Hull, Arthur W., Elkhart  
 Hurley, Anson, Muncie  
 Hyde, Carroll C., South Bend  
 Ingwell, Guy B., Knox  
 Irey, P. R., Plymouth  
 Irwin, Seth H., Anderson  
 Jackson, Charles E., Bluffton  
 Jenkins, Robert D., Indianapolis

Jinnings, Loren Earl, Garrett  
 Jones, Roland W., Indianapolis  
 Johns, Nicholas C., South Bend  
 Johnston, Richard M., Fort Wayne  
 Kamm, Bernard A., South Bend  
 Kammen, Leo, Indianapolis  
 Karn, John W., South Bend  
 Karsell, William A., Bloomington  
 Katterjohn, James C., Indianapolis  
 Kelly, Wendell C., Anderson  
 Kemp, John F., Michigan City  
 Kendrick, Frank J., Gary  
 Killian, Edgar W., Logansport  
 Kimbrough, Robert F., Fort Wayne  
 Kinzie, M. Dale, Indianapolis  
 Kirtley, William R., Indianapolis  
 Klatch, B. Z., Lafayette  
 Klaus, J. M., Crown Point  
 Klepinger, Harry E., Lafayette  
 Kobrin, Meyer W., Gary  
 Kohlstaedt, Kenneth G., Indianapolis  
 Kohrman, Ben, Michigan City  
 Komoroske, J. E., East Chicago  
 Kopcha, J. E., Gary  
 Kretsch, Russell W., Hammond  
 Krueger, John E., South Bend  
 Kruse, Walter E., Fort Wayne  
 Kubik, F. J., Michigan City  
 Kubley, James D., Plymouth  
 Kudele, Louis T., Whiting  
 Kunkler, Joseph, Terre Haute  
 Kurtz, W. A., Tipton  
 LaBier, C. Russell, Terre Haute  
 Ladig, Donald S., Fort Wayne  
 LaFollette, Forrest R., Whiting  
 Lamey, J. L., Anderson  
 Lamey, P. T., Anderson  
 Larmore, Joseph L., Anderson  
 Lava, Irving M., Michigan City  
 Lavengood, Russell W., Marion  
 Lawrence, Joseph C., Evansville  
 Lee, Glen Ward, Richmond  
 Lehman, K. M., Topeka  
 Lebiada, Henry S., Gary  
 Levi, Leon, Indianapolis  
 Lewis, George N., Gary  
 Lewis, Robert J., Lawrence  
 Linton, Charles E., Medaryville  
 Liss, E. C., South Bend  
 Loewenstein, W. L., Terre Haute  
 Logan, James Z., Richmond  
 Lovell, Martin H., Gary  
 Luginbill, Howard M., South Bend  
 Lutz, Georgianna, Gary  
 Lynch, Harold D., Evansville  
 Lynch, Otis R., Marengo  
 McArt, Bruce A., Indianapolis  
 McCallister, John William, Fort Wayne  
 McCarty, Virgil, Princeton  
 McCaskey, C. H., Indianapolis  
 McClintock, James A., Muncie  
 McConnell, William C., Sunman  
 McDonald, Joseph D., Evansville  
 McDonald, Ralph M., South Bend  
 McDowell, F. W., Muncie  
 McDowell, G. A., Fort Wayne  
 McFall, J. S. R., Fort Wayne  
 McFarland, Corley B., South Bend  
 McLean, James S., Hammond  
 McNairy, Donald J., Fort Wayne  
 Malouf, S. D., Peru  
 Maple, James B., Sullivan  
 Marks, Ora L., East Chicago  
 Marks, Salvo P., Hammond  
 Martin, Charles F., Mishawaka  
 Martin, Hugh E., Indianapolis  
 Martz, B. L., Indianapolis  
 Mason, Lester M., Terre Haute



- Masters, Robert J., Indianapolis  
 Mather, J. W., East Gary  
 Matthews, William M., Indianapolis  
 Mattox, Don M., Terre Haute  
 Mauer, Robert M., Brazil  
 Meiser, Robert D., Huntington  
 Mendenhall, Edgar N., Fort Wayne  
 Mendez, Carlos, Elkhart  
 Merchant, Raymond, Crown Point  
 Mercer, S. R., Fort Wayne  
 Merrell, Basil M., Rockville  
 Meyer, Milo G., Michigan City  
 Michaelis, S. C., Fort Wayne  
 Middleton, H. N., Indianapolis  
 Miller, H. Paul, Fort Wayne  
 Miller, Richard H., Fort Wayne  
 Miller, S. T., Elkhart  
 Mishkin, Irving, Elkhart  
 Molenda, R. V., Michigan City  
 Montgomery, Lall G., Muncie  
 Morris, Hyman, Gary  
 Mueller, Hilbert M., South Bend  
 Muhleman, C. E., LaPorte  
 Murphy, Joseph F., Hammond  
 Murphy, Josephine F., South Bend  
 Musacchio, F. A., Hammond  
 Nafe, Cleon A., Indianapolis  
 Nash, J. R., Albion  
 Nelson, Raymond E., South Bend  
 Nesbit, Leonard Locke, Anderson  
 Neumann, Kenneth O., Lafayette  
 Neuwalt, Frank, Gary  
 Nickel, Allen A., Bluffton  
 Nicosia, John B., East Chicago  
 Nie, G. M., Huntington  
 Nie, Louis W., Indianapolis  
 Niedermayer, Alfred J., Evansville  
 Nill, John H., Fort Wayne  
 Norris, Ernest B., Middlebury  
 Oppenheimer, Ernst, Evansville  
 Ornelas, J. P., Gary  
 O'Rourke, Carroll, Fort Wayne  
 Orr, W. Robert, Mishawaka  
 Osterman, L. H., Seymour  
 Otten, Claude F., Indianapolis  
 Owen, John E., Indianapolis  
 Oyer, Russell L., South Bend  
 Pancost, Vernon K., Elkhart  
 Parker, George F., Greencastle  
 Pauszek, Thomas B., South Bend  
 Payne, Arthur L., East Chicago  
 Pearson, Lyman R., Indianapolis  
 Peiffer, G. M., Hammond  
 Perrin, Kermit F., Fort Wayne  
 Petranoff, T. V., Indianapolis  
 Petronella, Samuel J., East Chicago  
 Phelps, Stephen R., Indianapolis  
 Piazza, L. F., Michigan City  
 Pickett, Robert D., Indianapolis  
 Pilot, Jean, Hammond  
 Plain, George, South Bend  
 Plank, Charles R., Michigan City  
 Polhemus, W. C., Anderson  
 Pooliton, George C., Bloomington  
 Poppewell, Arvine G., Indianapolis  
 Porro, Francis W., Evansville  
 Potter, Thomas P., Jr., South Bend  
 Quigley, Joseph B., Indianapolis  
 Rabb, Frank M., Indianapolis  
 Ramsey, Hugh S., Bloomington  
 Rang, Robert H., Washington  
 Rasmussen, Ruth F., South Bend  
 Ratcliffe, A. W., Evansville  
 Reed, Roger R., Anderson  
 Reed, William C., Bloomington  
 Remich, A. C., Hammond  
 Rhind, A. W., Hammond  
 Rice, Raymond M., Indianapolis  
 Richter, John C., LaPorte  
 Ridgway, Alton H., Indianapolis  
 Riggs, Floyd, Terre Haute  
 Rissing, Walter J., Fort Wayne  
 Roach, C. E., New Augusta  
 Rohr, J. H., Elkhart  
 Ropp, Harold E., New Harmony  
 Rosenbaum, David, Indianapolis  
 Rosenwasser, Jacob, Mishawaka  
 Rosevear, Henry J., Hammond  
 Ross, Alexander T., Indianapolis  
 Row, Perrie Q., Hammond  
 Rowdabaugh, L. Marshall, Indianapolis  
 Rubens, Eli, South Bend  
 Ruddell, Karl, Indianapolis  
 Ruddick, H. C., Evansville  
 Rudesill, Cecil L., Indianapolis  
 Rudolph, Franklin G., Hammond  
 Rudser, D. H., Whiting  
 Sacks, Harry J., Indianapolis  
 Sage, Charles Victor, Richmond  
 Sage, Russell A., Indianapolis  
 Sagel, Jacob S., Gary  
 Sahlmann, Hans, Fort Wayne  
 Sanderson, Robert B., South Bend  
 Sandock, Louis F., South Bend  
 Scamahorn, O. T., Pittsboro  
 Schaefer, C. Richard, Indianapolis  
 Schlademan, K. R., Fort Wayne  
 Schlaegel, T. F., Jr., Indianapolis  
 Schlesinger, Daniel J., Hammond  
 Schlesinger, Jacob, Columbus  
 Schmidt, Loren F., Indianapolis  
 Schmiedicke, P. H., Williamsport  
 Schmoll, Robert J., Fort Wayne  
 Schuchman, Gabriel, Indianapolis  
 Schulhof, M. A., Muncie  
 Schumaker, Robert A., Terre Haute  
 Schutt, J. B., Ligonier  
 Scott, Frank M., South Bend  
 Scott, V. Brown, Shelbyville  
 Scudder, J. A., Edwardsport  
 Selby, Keith E., South Bend  
 Sennett, C. M., South Bend  
 Sensenich, R. L., South Bend  
 Seyler, Anna Grace, Crown Point  
 Shafer, Marion R., Indianapolis  
 Shapiro, Joseph, East Chicago  
 Shattuck, John C., Brazil  
 Shelley, Edward S., South Bend  
 Shinabery, Lawrence, Fort Wayne  
 Shively, John A., South Bend  
 Shoup, H. B., Sr., Greentown  
 Shullenberger, Wendell A., Indianapolis  
 Shumacker, H. B., Jr., Indianapolis  
 Siekierski, Joseph M., Griffith  
 Silverman, Norman M., Terre Haute  
 Sims, J. Lawrence, Indianapolis  
 Sirlin, E. M., Mishawaka  
 Slaughter, John L., Evansville  
 Slominski, H. H., South Bend  
 Smith, Frederick R., Spencer  
 Smith, Herschel S., Bloomington  
 Smith, J. Ward, Indianapolis  
 Smith, James S., Muncie  
 Snively, W. D., Jr., Evansville  
 Snyder, Morris C., Richmond  
 Solomon, Robert D., Terre Haute  
 Spalding, Wendell L., Mishawaka  
 Spangler, Jesse S., Kokomo  
 Spenner, R. W., South Bend  
 Spolyar, Louis W., Indianapolis  
 Spurgeon, Orville E., Muncie  
 Sputh, Carl B., Indianapolis  
 Sroka, S. J., Highland  
 Stafford, W. C., Plainfield  
 Stangle, William, Bloomington  
 Stanley, John R., Muncie  
 Steele, Paul W., Evansville  
 Steffen, Arthur J., Wabash  
 Stephens, Lowell R., Covington  
 Stern, J. Lewis, Hammond  
 Stevens, Edwin W., Hammond  
 Stinson, Arthur E., Rochester  
 Stoelting, V. K., Indianapolis  
 Stout, Richard B., Elkhart  
 Stover, Wendell C., Boonville  
 Stoycoff, C. M., Gary  
 Stratigos, Joseph S., South Bend  
 Streck, Francis A., Lawrenceburg  
 Stroup, Tyler J., Indianapolis  
 Stubbins, William M., Crown Point  
 Studebaker, Lloyd R., LaGrange  
 Study, Robert S., Indianapolis  
 Stygall, James H., Indianapolis  
 Sullivan, John M., Terre Haute  
 Swihart, Leonard F., Elkhart  
 Tager, Stephen N., Evansville  
 Taylor, F. W., Indianapolis  
 Teixler, Victor A., Indianapolis  
 Templeton, Ames R., Mishawaka  
 Tennant, D. L., Fort Wayne  
 Test, Pasquale, Indianapolis  
 Thompson, Robert A., South Bend  
 Thornton, Harold C., Indianapolis  
 Tindal, Edward F., Muncie  
 Tindall, William R., Shelbyville  
 Tirman, Wallace S., Bluffton  
 Townsend, Ralph P., Westville  
 Troutwine, William R., Crown Point  
 Troy, Jack, Whiting  
 Tyler, Robert L., Calumet City  
 Vail, George A., Lawrenceburg  
 VanNess, William C., Summitville  
 Verplank, Grover L., Gary  
 Vietzke, Paul, Valparaiso  
 Viney, Charles L., Logansport  
 Vivian, Donald E., Indianapolis  
 Vore, H. A., East Chicago  
 Voyles, Glenn O., Twin Falls  
 Vurpillat, F. J., South Bend  
 Walker, Adolph P., Hammond  
 Walters, E. A., Gary  
 Warfield, C. H., Fort Wayne  
 Washington, G. Kenneth, Gary  
 Weinstock, Adolph, Rolling Prairie  
 Weiss, Eugene, South Bend  
 Weiss, Henry G., Evansville  
 Weiss, Jason, Indianapolis  
 Welty, S. G., Fort Wayne  
 White, Raymond L., Boise  
 Whitlock, Francis C., Mishawaka  
 Whitlock, Merle E., Mishawaka  
 Wiedemann, Frank W., Terre Haute  
 Wiersma, Alvin F., Marion  
 Wilhelm, Agatha, South Bend  
 Williams, A. Berniece, Fort Wayne  
 Williams, Alexander S., III, Fort Wayne  
 Williams, Aubrey H., Fort Wayne  
 Williams, Charles David, Indianapolis  
 Williams, Hugh J., Morocco  
 Wilson, Fred M., Indianapolis  
 Wilson, John W., Indianapolis  
 Wilson, Roland B., Fort Wayne  
 Witham, R. L., Culver  
 Wixted, John F., Mishawaka  
 Wixted, Julia L., Mishawaka  
 Wood, Frederic H., Hammond  
 Worley, J. P., Indianapolis  
 Wright, J. William, Indianapolis  
 Wyatt, James L., Fort Wayne  
 Wynn, Justice F., Evansville  
 Yoder, A. C., Goshen  
 Young, C. Curtis, Jr., Evansville  
 Young, George M., Gary  
 Zeiger, Irvin, South Bend  
 Zimmerman, William H., Dublin  
 Zweig, Elmer S., Fort Wayne

# The Fourth Estate Looks At Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

## ISN'T THIS SOCIALIZED MEDICINE?

Two out of every three patients treated free in Veterans Administration hospitals in the United States have illnesses or injuries that did not result from service in the armed forces. We do not believe it was the intent of Congress to provide free medical care to all servicemen for the rest of their lives, but under the law as it is written that has been the effect of the present legislation. Any veteran can be admitted to a V.A. hospital for free care simply by signing a paper that states that "in his opinion" he cannot afford to pay. If he has an income of \$20,000 a year and breaks his arm in an automobile accident, he can get treated and hospitalized at the taxpayers' expense if he just says he thinks he cannot pay the bill.

We see no reason why all former servicemen should be provided with lifelong free medical care. If they all took advantage of their right under this law, the cost would be staggering.

Certainly Congress should provide the very best care for veterans with service connected disabilities. It might well supply free care to veterans who truly cannot afford to pay. But to provide free care to all veterans is nothing less than socialized medicine for a specially favored group of about 15,000,000 citizens.

We do not agree with those who maintain that investigation of a veteran's financial status would create red tape, confusion and additional cost. The very threat of investigation would keep many chiselers out. By far the large majority of veterans can afford to pay their ordinary medical expenses. Only the minority who cannot do so and those whose difficulties were caused while they were serving their country deserve the special treatment now available to all veterans.

—*Indianapolis Star*

## GOOD PLAN FOR MEDICAL AID

A revised medical aid program for the Fayette County Welfare Department has been devised by the new medical advisory committee. It is designed to cut medical costs by ending the wasteful practices of giving aid when it is not needed, of giving away free false teeth, hearing aids and glasses when they are not absolutely necessary, of eliminating the use of expensive drugs and limiting house calls to welfare patients. Dr. Frank H. Neukamp, chairman of the medical advisory committee outlined this new plan to the Indiana State Medical Association recently. He stated that great savings can be expected simply by limiting medical aid to really necessary use.

Dr. Walter L. Portteus of Franklin has recommended that all county medical societies study this Fayette County plan with a view toward instituting it throughout the state. Certainly it is a realistic medical aid program that looks to the burdens of the taxpayer while at the same time insuring that welfare patients will receive good medical care when they need it. Only the nonessentials would be eliminated by the Fayette plan. And fees for injections, for instance, would be set at the low cost of \$1. Drugs would not be paid for by welfare departments unless recommended by doctor's prescription.

County welfare departments should work closely with their county medical societies to make sure that their medical aid programs are not wasteful and discriminatory and that people on welfare are not permitted to abuse the program. The Fayette plan provides a sound basis for adoption of similar plans by every county welfare department in the state in the interests of the taxpayers' pocketbook and fulfilling the true needs of welfare recipients.

—*Indianapolis Star*



## The Use of ACTH and Cortisone in the Treatment of Rheumatic Fever— A Preliminary Statement on the COOPERATIVE RHEUMATIC FEVER STUDY

EARLY in 1951 an international study of the treatment of rheumatic fever was set up with the object of measuring the relative values of ACTH, cortisone, and aspirin. This cooperative study, first of its kind in this field, is being conducted in 13 research centers in the United States, Great Britain, and Canada by the American Heart Association's Council on Rheumatic Fever in conjunction with the British Medical Research Council.

A preliminary report of the findings was made by a Panel of investigators engaged in the study at a joint scientific session of the Council on Rheumatic Fever and the American Rheumatism Association in Chicago on June 7, 1952. A summary statement, which follows, was presented by the Moderator for the Panel, Dr. David D. Rutstein, Boston, Chairman of the Committee on Criteria and Standards of the Council on Rheumatic Fever.

The text of the statement is as follows:

"A group of investigators in the United Kingdom, Canada and the United States initiated in January 1951 a cooperative study on the relative value of ACTH, cortisone and salicylates in the treatment of rheumatic fever and the prevention of rheumatic heart disease. The plan of study provides for uniform criteria for the diagnosis of rheumatic fever and for the degree of rheumatic activity required for the admission to the study, the random allocation of patients to the three treatment groups, a defined dosage schedule of the drugs for a fixed period of time, a specified period of observation following treatment and a long term follow up schedule. It also lays down precisely the frequency and type of clinical and laboratory observations to be carried out on each patient.

"To date, in all three countries, 658 cases have been admitted to the study and the analysis of rather less than half of these is the basis of the preliminary report. These cases were analyzed for changes in those symptoms, signs and laboratory observations usually considered important in evaluating the course of acute rheumatic fever. In the type of cases admitted to the trial and with the regime of treatment laid down, it appears that individual symptoms, signs or laboratory observations may have been affected more favorably by one or another of these three drugs, but no consistent pattern is evident. In short, no firm conclusions can at present be drawn concerning the drug most effective in the control of the acute illness. The cases have not been under observation sufficiently long to provide data on the prevention of rheumatic heart disease.

"Admission of new cases to the study will be brought to an end later this year. It is anticipated that a total of 750 cases will be available in all three countries for complete and detailed analysis of the effects of the drugs on the acute course of the disease and later, after adequate follow up, on the prevention of rheumatic heart disease."

### Committee on Heart Disease

Stuart R. Combs, M.D., *Chairman*  
Dan Urschel, M.D.  
Walter S. Fisher, M.D.  
Richard Nay, M.D.  
C. J. Clark, M.D.  
Philip W. Rothrock, M.D.

In the September JOURNAL on this page you will find the curriculum for the Instructional Courses to be given on Tuesday, October 28, 1952, in Murat Temple during the annual session of the Indiana State Medical Association. The curriculum will be accompanied by an order blank on which you may make selections and accompany it with your check for reserved tickets.

Courses will be offered from the following list of subjects:

- |  |   |
|--|---|
| Bedside and Office Diagnosis of Cardiac and Vascular Problems. | The Management of Diabetes Mellitus.  |
| Pediatric and Infant Feeding Problems.                         | How to Improve Your Own Public Relations  |
| The Diagnosis and Treatment of Common Skin Diseases.           | The Office Diagnosis and Treatment of Common Genitourinary Diseases.              |
| The Treatment of Anemias and Allied Conditions.                | The Management of Comatose States.  |
| The Management of the Neurotic.                                | Vertigo and Allied Conditions.  |
| Constipation—Diarrhea—Indigestion.                             | The Backache Problem.   |
| The Demonstration of a Physical and Neurological Examination.  | The Diagnosis and Management of Common Gynecological Problems.                    |
| Obstetrical Emergencies.                                       | The Newer Management of Coronary Disease, Rheumatic Fever and Congestive Failure. |
| The Differential Diagnosis of Fatigue States.                  | Cancer.   |
| The Treatment of Burns and Shock.                              | Salt Metabolism in Heart Failure and Hypertension.                                |
| The Management of Anorectal Conditions.                        | Shoulder and Upper Extremity Pain.  |
| The Newer Drugs.   | The Overactive and Inactive Thyroid.  |
| Premarital and Marital Counseling.                             | Management of the Elderly.  |
| The Headache Problem.  | The Diagnosis and Treatment of Respiratory Diseases.                              |

Each of these courses will be given by a member of the Association whose principal interest in practice lies in the field he will discuss. Every effort will be made to make the courses of immediate value to the auditor.

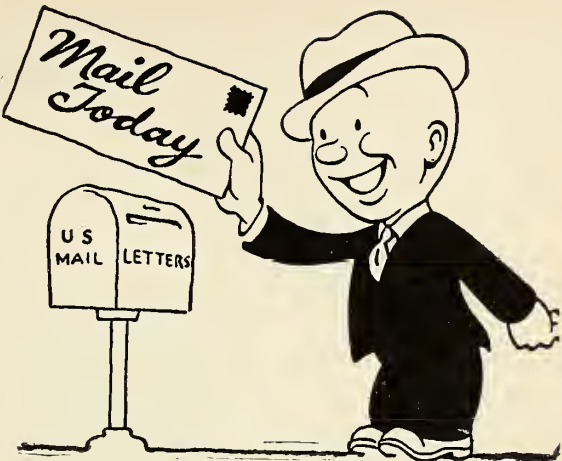
Be ready to select the courses you wish to attend when the September JOURNAL arrives.



# Time to Make Hotel Reservation

Going to attend the annual session of the Indiana State Medical Association in Indianapolis on Tuesday, Wednesday and Thursday, October 28, 29 and 30, 1952?

It's time to make your hotel reservation.



Hotels	Rates (Start)	
	Single	Double
Antlers, 750 N. Meridian.....	\$4.25	\$6.25
Barnes, 233 McCrea Place.....	\$3.00	\$4.00
Barton, 505 N. Delaware.....	\$2.75	\$4.00
Claypool, 14 N. Illinois.....	\$4.60	\$6.30
Harrison, 51 N. Capitol.....	\$4.00	\$6.00
Jones, 248 S. Illinois.....	\$2.50	\$4.50
Lincoln, 117 W. Washington.....	\$4.50	\$6.75
Linden, 311 N. Illinois.....	\$2.00	\$3.50
Marott, 2625 N. Meridian.....	\$8.00	\$10.00
New English, 6 W. Michigan.....	\$3.00	\$5.00
Pennsylvania, 947 N. Penn.....	\$3.75	\$5.50
Riley, 155 W. 16th.....	\$2.50	\$4.50
Severin, 201 S. Illinois.....	\$4.50	\$6.50
Sheffield, 958 N. Pennsylvania.....	\$4.00	\$7.00
Spink Arms, 410 N. Meridian.....	\$3.50	\$6.00
Warren, 123 S. Illinois.....	\$4.75	\$6.75
Washington, 34 E. Washington.....	\$4.25	\$5.75

## TIME OF EVENTS

### TUESDAY, OCTOBER 28

Instructional Courses, Stag Party, Golf, Trapshoot, Party for doctors and wives.

### WEDNESDAY, OCTOBER 29

Scientific Program, entertainment at night for doctors and wives, Murat Theater.

### THURSDAY, OCTOBER 30

Scientific Program, reception for Fifty Year Club, annual dinner and dance.

### FORM FOR MAKING HOTEL RESERVATION

(Clip out this form, fill it out, and mail to hotel of your choice)

You are requested to reserve the following accommodations during the annual meeting of the Indiana State Medical Association, October 28, 29 and 30, 1952, or for such other period as may be indicated herein.

☐ Single Room with bath

☐ Double Room with bath

Price.....

☐ Twin Bed Room with bath

☐ Suite

Arrival date .....A. M. ....P. M.

Departure date .....A. M. ....P. M.

Name .....

Address .....

.....

.....

## Deaths

**Jesse E. Ferrell, M.D.**, of Fortville, who was president of the Indiana State Medical Association in 1946, died suddenly on July 2, at the age of seventy-one. He had been active in association affairs since 1932, serving on Postgraduate Study, State Fair, Medical Relief, Budget, Medical Service and Public Relations, Establishment of Board of Certification for the General Practice of Medicine, Inter-Professional Health, Rural Health and Auditing Committees. He was a member of the House of Delegates for twenty-five years. He had also served as alternate delegate to the A.M.A. Doctor Ferrell was a graduate of the Medical College of Indiana, in Indianapolis, in 1903. He practiced in Eden for twelve years, and then moved to Fortville, where he had continued in practice ever since. He was a member of the Hancock Medical Society, the Indiana State Medical Association, and the American Medical Association.



**John M. Cunningham, M.D.**, of Indianapolis, died on June 29, at the age of seventy-five. He was a graduate of the Medical College of Indiana, in Indianapolis, in 1904, and had practiced in Indianapolis since that time. Doctor Cunningham was a senior member of the Indianapolis Medical Society and the Indiana State Medical Association, and was a member of the American Medical Association.

**Robert Martin Moore, M.D.**, of Indianapolis, died on June 23, after a long illness. He was sixty-seven years of age. He graduated from Indiana University School of Medicine in 1913, and had practiced continuously in Indianapolis since that time, except for the period of his service overseas in World War I. Doctor Moore was a member of the Indianapolis Medical Society, the Indiana State Medical Association, and the American Medical Association.

**Melvin Delbert Price, M.D.**, of Nappanee, died on May 31, after a brief illness. He was eighty-one years of age. A graduate of the Medical College of Indiana, in Indianapolis, in 1900, he had practiced in Nappanee since that time. Doctor Price was a senior member of the Elkhart County Medical Society and the Indiana State Medical Association, and was a member of the American Medical Association.

**Amos Reusser, M.D.**, of Berne, died on July 9, after a very short illness, at the age of eighty-two. He graduated from the Chicago Homeopathic Medical College in 1897. He was a senior member of the Adams County Medical Society and the Indiana State Medical Association, and was a member of the American Medical Association.

**Urbana Spink, M.D.**, of Indianapolis, died on July 5, at the age of seventy-three. She graduated from the Woman's Medical College of Pennsylvania, in Philadelphia, in 1899, and had practiced in Indianapolis continuously since that time. She was a member of the Indianapolis Medical Society, the Indiana State Medical Association, and the American Medical Association.



## Deaths

**Evan C. Totten, M.D.**, of Madison, died on June 2 after an extended illness, at the age of seventy-seven. Graduating from the Medical College of Ohio, in Cincinnati, in 1900, Doctor Totten established a practice in Madison upon completion of his internship, and continued to practice there until his recent illness. He was a senior member of the Jefferson County Medical Society and the Indiana State Medical Association, and was a member of the American Medical Association.

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**Bradford Warren, M.D.**, of Marshall, died suddenly on June 6, at the age of seventy-one. A graduate of the Hospital College of Medicine, in Louisville, in 1906, he practiced in Kentucky for five years before moving to Marshall in 1912. He had practiced there ever since. Doctor Warren was a member of the Parke-Vermillion County Medical Society, the Indiana State Medical Association, and the American Medical Association.

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**George W. Copeland, M.D.**, of Vevay, died suddenly on June 7, at the age of seventy-nine. He was a graduate of the Kentucky School of Medicine, in Louisville, in 1896, and practiced in Fairview, Moorefield, Indianapolis and Versailles, before locating in Vevay, where he had remained since that time. Doctor Copeland was a senior member of the Switzerland County Medical Society and the Indiana State Medical Association, and was a member of the American Medical Association.

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**John S. Haynes, M.D.**, of Evansville, died on June 5, at the age of thirty-four. He was a graduate of Harvard School of Medicine in 1949, and had served as industrial physician for Standard Oil and U. S. Steel Companies in Chicago before moving to Evansville last January.

**Robert Clarence Stephens, M.D.**, of Plymouth, died on June 8, at the age of eighty-three. He had been in ill health for the past two years, and had retired from active practice in 1950. He graduated from the Missouri Medical College in St. Louis in 1893, and practiced at Bennett, Iowa until 1897, when he moved to Plymouth, where he practiced until his retirement. Doctor Stephens was a senior member of the Marshall County Medical Society and the Indiana State Medical Association, and was a member of the American Medical Association.

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**George Wiggins, M.D.**, of New Castle, died on May 17, at the age of forty-eight. He graduated from the St. Louis University School of Medicine in 1931, and practiced in New Castle ever since. He was a member of the Henry County Medical Society, the Indiana State Medical Association, and the American Medical Association.

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**Harry E. English, M.D.**, of Rensselaer, died on June 7, after a brief illness. He was fifty-four years of age. He was a 1921 graduate of Indiana University School of Medicine, and had practiced in Rensselaer since 1922. He was a veteran of World War I. Doctor English was a member of the Jasper-Newton County Medical Society, the Indiana State Medical Association, and the American Medical Association.

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**Henry Lohrmann, M.D.**, retired physician of Indianapolis, died on June 9 after a long illness. He was eighty-one years of age. He received his medical degree from the Jefferson Medical College of Philadelphia in 1900, and was a lifelong resident of Indianapolis.

## News Notes

### Lilly Isolates New Antibiotic

A promising new orally administered antibiotic, effective against a wide variety of organisms and remarkably free of toxic effects, is reported in the June issue of the journal, *Antibiotics and Chemotherapy*. The name 'Ilotycin' (Erythromycin, Lilly) has been given the new agent which is a discovery of the Lilly Research Laboratories. 'Ilotycin,' which climaxes a five-year program of intensive research in this field, is obtained by culture of an actinomycete isolated from a sample of soil collected in the Philippine Islands.

Preliminary clinical trial has been carried on in more than 100 patients without appearance of gastrointestinal disturbances seen with some other antibiotics and without evidence of toxic effects or sensitization reactions.

The new antibiotic does not destroy the colon bacillus in the intestinal tract and thereby the normal flora of the bowel remains unaffected.

Although clinical trials look encouraging, several months will elapse before 'Ilotycin' is thoroughly investigated and considered ready for general distribution.

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The **New York Academy of Medicine** announces its twenty-fifth Graduate Fortnight to be held October 6 to 17. The program will be devoted to Hormones in Health and Disease. Morning panel discussions, afternoon hospital clinics and evening lectures, together with scientific exhibits, are scheduled. Registration fee is \$10.00. A program may be obtained by writing Graduate Fortnight, 2 E. 103 St., New York 29, New York.

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**Dr. Edward J. Hanley** is now associated in the practice of orthopedics with **Dr. Reid L. Keenan** at 615 Hume Mansur Building, in Indianapolis. Doctor Hanley is a 1945 graduate of Western Reserve University School of Medicine, and recently completed postgraduate training in orthopedics and pathology. He is also a Navy veteran.

The 80th Annual Meeting of the **American Public Health Association** and the annual meetings of 38 related organizations will be held in the Public Auditorium, Cleveland, Ohio, October 20-24. Dr. Reginald M. Atwater, Executive Secretary of the Association, has announced.

The Lasker awards for 1952 for outstanding contributions in medical research and public health administration will be presented on Tuesday evening, October 21. The Sedgwick Memorial Medal, given for distinguished service in public health, will be awarded at the Banquet Session on Thursday evening, October 23rd.

Local arrangements are being made under the direction of Dr. Harold J. Knapp, Commissioner of Health of Cleveland.

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Dr. Karl A. Meyer, President of the **Cook County Graduate School of Medicine**, has announced the receipt by the school of a donation of \$100,000 from the Joseph and Helen Regenstein Foundation. Presentation of the donation was made on the occasion of the official opening of the school's new building located at 707 South Wood Street, Chicago, Illinois.

Mr. Joseph Regenstein, who established the Foundation which made the gift, is a prominent Chicago industrialist. The proceeds of the donation will be used to expand the school's activities in the field of graduate medical education.

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At the 18th annual meeting of the American College of Chest Physicians, held in Chicago in June, **Dr. James H. Stygall**, of Indianapolis, was elected second vice-president. **Dr. Jerome V. Pace**, of New Albany, is a member of the Board of Governors.

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**Dr. J. O. Ritchey**, of Indianapolis, was elected to the Board of Governors of the American College of Physicians when that organization met recently in Cleveland.



**E. Rogers Smith, M.D.**, Indianapolis, recently received a plaque for his outstanding contribution to the field of automobile racing. The handsome trophy was presented at a dinner meeting of the Champion 100-Mile-An-Hour Club by James F. Lewis, Jr., vice president of the Champion Spark Plug Co. Doctor Smith has been a member of the Indianapolis Speedway's medical organization for 25 years, and until his retirement last year, had been its chief for many years.

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**Dr. Stephen J. Donovan**, of Michigan City, is now senior surgeon on the staff of the VA Hospital in Lake City, Florida.

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**Dr. Robert Dilworth**, formerly of Cleveland, has opened an office in Montpelier for the practice of medicine and surgery. He is a graduate of Western Reserve University, and took postgraduate work in surgery.

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**Dr. Robert H. K. Foster** has joined **Dr. Charles F. Deppe** and **Dr. Lyman D. Eaton** in the practice of medicine in Franklin. Doctor Foster is a graduate of Rush Medical College in Chicago.

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A 1951 graduate of Indiana University School of Medicine, **Dr. Raymond L. Newnum** has opened an office for the practice of medicine in Hagerstown. He interned at Indiana University Medical Center, and is a veteran of World War II.

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**Dr. David C. Straus**, of Michigan City, has accepted a position as medical officer at the Pueblo, Colorado, Ordnance Depot.

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**Dr. David G. Wagner**, of Bedford, has opened an office for the practice of medicine in Goshen. He is a 1951 graduate of Indiana University School of Medicine, and spent his internship at Indianapolis General Hospital. Doctor Wagner is a veteran of World War II.

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**Dr. Francis C. Whitlock**, of Indianapolis, has moved to Mishawaka to establish a medical practice there. A graduate of Indiana University School of Medicine, Doctor Whitlock has practiced in Indianapolis for seven years. He is a veteran of World War II.

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**Dr. Frank W. Countryman**, a 1944 graduate of Yale, has opened an office at 3233 North Meridian Street, in Indianapolis, for the practice of psychiatry and neurology. He recently completed postgraduate work at Winter VA Hospital in Topeka, Kansas.

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**Dr. Edwin N. Barnum**, a 1945 graduate of Indiana University School of Medicine, is now in the practice of radiology in San Mateo, California.

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**Dr. Robert P. Knowles** is now associated with **Dr. David L. Smith** in the practice of obstetrics and gynecology, at 2901 North Meridian Street in Indianapolis.

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**Dr. Edwin S. McClain**, a 1945 graduate of Indiana University School of Medicine, has opened an office for the practice of obstetrics and gynecology at 414 Hume Mansur Building, in Indianapolis.

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Upon completion of his internship at Indianapolis General Hospital, **Dr. James R. Daggy** opened an office for general practice on July 1 at Richmond.

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**Dr. Frederick R. Brown** has opened an office for general practice in Ellettsville. He is a 1951 graduate of Indiana University School of Medicine, and recently completed his internship at Indianapolis General Hospital.

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**Dr. Herbert C. Ashmore** has opened an office for the practice of medicine in Hebron. He is a graduate of Indiana University School of Medicine, and interned at Gary Methodist Hospital. He is a veteran of World War II, and spent five years in Alaska, the Aleutians and Hawaii.

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**Dr. William F. Buechler** is now associated in practice with **Dr. W. A. Scea** and **Dr. Merl Hoppenrath** in Elwood. Doctor Buechler is a graduate of the Medical College of Alabama, in Birmingham, took postgraduate work at the University of North Dakota, and has been in practice at the VA Hospital in Marion for the past ten months.

## *Indiana University News Notes*

**John D. VanNuys, M.D.**, Dean of the Indiana University School of Medicine, was awarded an honorary Doctor of Science degree during the 114th commencement of Wabash College, June 8, at Crawfordsville.

Graduated from Wabash College 23 years ago with an A.B. degree, Dr. VanNuys enrolled in the Indiana University School of Medicine, receiving his M.D. degree in 1936. He has served successively as Director of Admissions and Medical Director for the University hospitals, and as Executive Secretary of the Indiana University School of Medicine. He became Dean of the Medical School five years ago and has been active in modernizing the curriculum, expansion of the faculty to instruct an increased number of students, improvement of hospital services and in the development of a broad program of medical research.

For his work in the field of public health Dr. VanNuys has previously received the Distinguished Service Award of the Indiana Public Health Association, and an honorary membership in the Indiana Academy of General Practice.

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**Major General George E. Armstrong**, Surgeon General USA, who received his M.D. degree from Indiana University in 1925 and has been a frequent visitor on the Medical School campus in recent years, was awarded the honorary Doctor of Laws degree by Indiana University, June 16.

Similarly honored was Major General Lewis B. Hershey, director of the U.S. Selective Service and also an I. U. Alumnus. Dr. Charles A. Krauss, Professor Emeritus of Chemistry at Brown University, was accorded an honorary Doctor of Science degree.

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**Dr. Ko Kuei Chen**, Professor of Pharmacology at the Indiana University School of Medicine and director of pharmacologic research for Eli Lilly & Co., was awarded an honorary Doctor of Science degree by his alma mater, the University of Wisconsin, June 20.

Award of construction contracts for two new buildings at the Indiana University Medical Center, one a cancer research unit and the other a service and stores structure, has been announced in Bloomington by J. A. Franklin, vice president and treasurer of the University.

Construction of the two buildings to begin at once will cost \$521,948 for the cancer unit and \$316,411 for the service and stores addition to the Medical Center.

The funds for construction include \$675,000 appropriated by the last session of the General Assembly for building at the Medical Center and a grant of \$126,350 for the cancer unit made by the United States Public Health Service.

The cancer research unit of three stories and basement will be an extension of the new research wing of the James Whitcomb Riley Hospital. It will accommodate the Medical Center's expanding cancer research, much of which is being financed through grants and private gifts. It will contain a small clinical metabolic unit for cancer patients. The building, similar in architecture to the Riley research wing and to be constructed of brick with Indiana limestone trim, has been designed by Robert Frost Daggett and Associates, of Indianapolis, with Ammerman, Davis and Stout, also of Indianapolis, as consulting engineers.

The service and stores building of two floors and basement, built of reinforced concrete and brick, will be erected north of the Center's Rotary Convalescent Hospital. It will house the Center's maintenance carpenter, paint, heating, plumbing, and machine shops, part of which have been in the Riley Hospital, and also serve a central stores building. It has been designed by the J. M. Rotz Engineering Co., of Indianapolis, with McGuire and Shook, also of Indianapolis, as consultants.

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**Dr. R. N. Harger**, Professor of Biochemistry and Toxicology, discussed the use of the "drunkometer" which he developed, as a means of testing alcoholic content of the blood, at a meeting of the Southern Police Institute in Louisville.



**Dr. George J. Garceau**, Chairman and Professor of Orthopedic Surgery, Indiana University School of Medicine, was among the guest speakers appearing before the Joint Meeting of the English Speaking Orthopedic Associations, held in London. Dr. Garceau presented a paper, "Filum Terminale Syndrome." He is the second member of the Medical School faculty to appear on an international specialty program in recent weeks.

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**Dr. Edwin A. Lawrence**, Professor of Surgery and Cancer Coordinator, Indiana University School of Medicine, was the principal speaker at three cancer programs held in June by the Louisiana Academy of General Practice at Independence, Alexandria and Shreveport. Dr. Lawrence discussed, "Problems in Gastrointestinal Cancer."

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A report on cancer research projects sponsored by the Indiana Elks Association at the Indiana University Medical Center, was presented at the fraternal order's state meeting, June 21, by Dean John D. VanNuys. A substantial contribution for continuing the research program was announced at the meeting.

Friends from over the state and the Bloomington campus joined with the Medical Center staff on June 12 in honoring **Mr. J. B. H. Martin**, who retired June 30 after 19 years as Administrator of the Indiana University Medical Center and a total of 39 years service with the University. Mr. Martin had been intimately associated with the establishment and development of the Medical Center.

He is being succeeded as Administrator by **Mr. Edmund J. Shea**, Assistant Administrator for the past 13 years, who was installed last month as president of the Indiana Hospital Association.

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**Dr. Robert B. Forney**, Assistant Professor of Toxicology, is president-elect of the Indiana Division of the American Chemical Society.

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The Cerebral Palsy Clinic, conducted at James Whitcomb Riley hospital by the I. U. School of Medicine and the Division of Services for Crippled Children, State Welfare Department, observed its 15th anniversary on May 28. Now nationally recognized, the clinic has served 2,532 patients since its establishment.

#### A.M.A. WASHINGTON OFFICE NEWS

**FDA Releases Isoniazid for Prescriptions.** Food and Drug Administration has given drug manufacturers authority to distribute the new anti-tuberculosis drug, isonicotinic acid hydrazide (isoniazid), for use under "close medical supervision." *This means all licensed physicians may prescribe the drug for their patients.* The FDA announcement said approval was granted on the basis of clinical and pharmacological studies reported by drug manufacturers. FDA emphasized that release of the drug implies no approval or endorsement by the agency.

Packages delivered to the druggist by the manufacturer must state: "for use in treatment of streptomycin-resistant tuberculosis, under close supervision of physician," as well as carry the usual caution: "Federal law prohibits dispensing without prescription."

Medical officers of FDA said there has not been sufficient study to determine the place of the new drug in the treatment of tuberculosis. The agency adds: "Some tuberculosis authorities are of the opinion that the new drug is less effective for patients who are responding to treatment with a combination of streptomycin and para-aminosalicylic acid. *There is growing concern about the possible effects of promiscuous and indiscriminate use . . . there have been reports of the emergence of resistant strains of tubercle bacilli after varying periods of treatment . . . the drug should be used in selected cases where it may be a life-prolonging or life-saving measure.*"

(AMA'S Council on Pharmacy and Chemistry has taken action similar to FDA's regarding various brands of the drug submitted to it for consideration.)

## Society Reports

### INDIANA STATE MEDICAL ASSOCIATION EXECUTIVE COMMITTEE

June 17, 1952

Roll call showed the following present: C. J. Clark, M.D., chairman; W. L. Portteus, M.D.; Paul D. Crimm, M.D.; Wemple Dodds, M.D.; Roy V. Myers, M.D.

Frank B. Ramsey, M.D., editor of *THE JOURNAL*; Albert Stump, attorney; James A. Waggener, executive secretary, and Robert J. Amick, field secretary.

#### Membership Report

Number of members, June 17, 1952 ----- 3,584\*  
 Number of members, June 17, 1951 ----- 3,530  
 Gain over last year ----- 54

\* Includes 66 in military service (gratis)  
 108 \$10 members (residents and interns)  
 234 senior members  
 1 honorary member  
 53 members, dues remitted by Council

#### Treasurer's Office

Upon motion of Drs. Myers and Dodds the committee authorized the investment of \$1,000 of the Medical Defense Fund in government securities.

Statements of receipts and expenditures and report on budget for May for the association committees and *THE JOURNAL* were approved.

#### Legislative Matters

##### National

The executive secretary gave a report covering the actions of the House of Delegates of the American Medical Association on H. R. 7800 and the Magnuson Committee.

##### Local

The association attorney and the executive secretary gave a report on the activity with regard to preparing platform suggestions for both the State Democratic and Republican parties.

#### Organization Matters

Upon motion of Drs. Myers and Portteus, statements from the association attorney were authorized for payment.

The request of *The Indiana Farmers Guide* for the purchase of space in the centennial edition for the Indiana State Fair was turned down, on motion of Drs. Portteus and Crimm.

*Medical Education Foundation Trust.* The executive secretary announced that by mail ballot the Council had approved the formation of the Medical Education Foundation Trust.

*Blue Shield—resolution adopted by House of Delegates, interim session.* Mr. Saylor, executive vice-president of the Blue Shield Plan, discussed the action of the last session of the House of Delegates requesting Blue Shield to issue split checks for services rendered by physicians and surgeons under its present indemnity schedule. He told of some of the problems encountered in attempting to carry out the wishes of the House of Delegates, and upon motion of Drs. Portteus and Crimm, it was decided that this matter should be referred back to the Permanent Study Committee on Medical Care Insurance for further study, and that it should also be called to the attention of the Council.

#### The Journal

*Report on advertising* was accepted by consent:

Total, June, 1951 -----	\$2,102.49
Total, June, 1952 -----	2,072.10

*Wabash Life Insurance Company ad.* The association attorney reported on the proposed ad of the Wabash Life Insurance Company in which he stated he felt it was not in accordance with the terms of their contract and by consent he was to see that the copy is changed to comply with the terms of their policy.

The editor solicited the opinion of the committee regarding expanding the editorial staff of *THE JOURNAL* by naming several associate editors throughout the state. The committee thought this was worthwhile and recommended that Doctor Ramsey procure permission of the Council at its next meeting for doing this.

The Committee on Public Policy and Legislation requested permission to insert a four-page bulletin in *THE JOURNAL* at a cost of \$120 an issue for the next few months. Upon motion of Drs. Dodds and Portteus, permission was granted.

There being no further business, the committee adjourned to meet again at 6:00 p.m., Saturday, July 26, 1952, at the Athenaeum, Indianapolis.

### COUNCILOR DISTRICT MEETING

#### SECOND DISTRICT

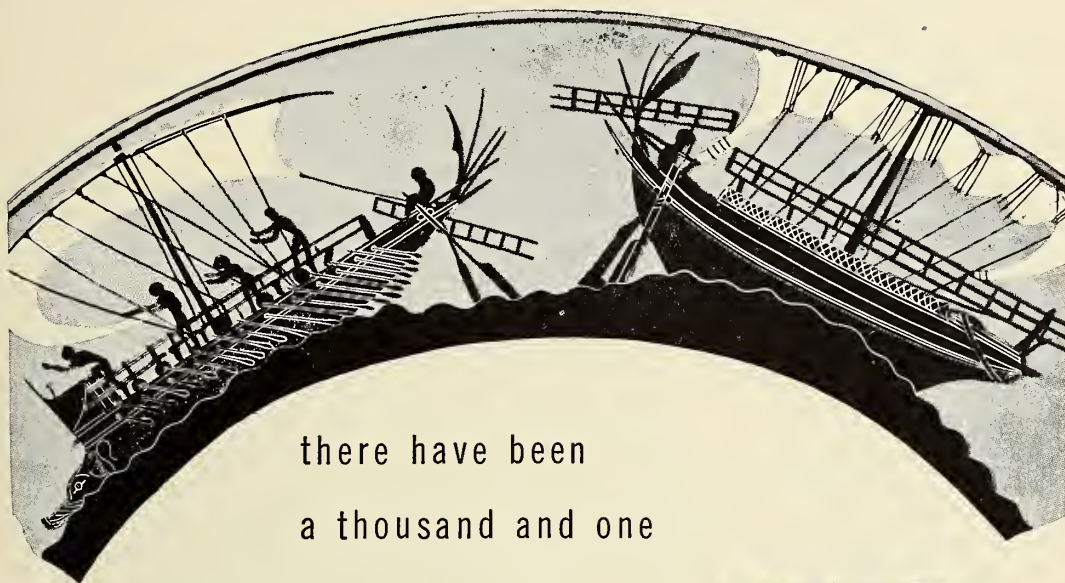
The Second District Medical Association was entertained by the Greene County Medical Society on Thursday, June 19, at the Linton Country Club. Fifty members and guests were present. Dinner was served at 6:30 p.m.

The program was presented through courtesy of The Road Show of The Indiana Academy of General Practice. The speakers were as follows:

*(Continued on page 834)*



Ever since man went down  
to the sea in ships



there have been  
a thousand and one  
suggestions for  
the relief of  
motion sickness.



War ship and merchant ship,  
about 500 B. C.; from painted  
vase found at Vulci in Etruria,  
now in the British Museum.

Now, relief from this age-old malady with

**DRAMAMINE®**

BRAND OF DIMENHYDRINATE

Available as: Tablets—50 mg.

Liquid—12.5 mg. per 4 cc.

**SEARLE** RESEARCH IN THE SERVICE OF MEDICINE



*Patronize Your Advertisers*

X-ray Diagnosis of Unusual Cases—Chester A. Stayton, Jr., M.D.

Bronchiogenic Carcinoma—John Thompson, M.D.

Questions and Answers on X-ray Diagnosis—Chester A. Stayton, Jr., M.D.

Chest Pathology Besides Carcinoma—John Thompson, M.D.

At the afternoon business meeting Owen-Monroe County Society invited the Second District to meet with them. Dr. Hugh S. Ramsey of Bloomington was elected president. The present secretary was held over in office.

Motion by Dr. Ramsey and second by Dr. Blazey that a resolution be adopted whereby the members of the Second District conduct a "Grass roots" informational campaign against H. R. 7800. This was carried after Dr. Ramsey presented it and a copy is attached to the minutes.

Distinguished guests: Dr. J. Wm. Wright, president of the state association, also secretaries Waggener and Amick.

### LOCAL SOCIETY REPORTS

Camp Atterbury Medical Society members met on May 19. A business meeting preceded the scientific session. The guest speaker was Dr. John Campbell, of Indianapolis, who gave a review of radioactive isotopes.

Another meeting was held on June 19, when five case reports were presented, representing unusual clinical and roentgenographic findings.

Benton County Medical Society members met at the Country Club in Fowler on May 29. Ten members were present for the business meeting. The Woman's Auxiliary met at the same time.

Fountain-Warren County Medical Society members met in Attica on June 5. This was a dinner meeting, and eleven members and their wives were present.

Shelby County Medical Society members and their wives held their annual picnic June 25 at the summer cottage of Dr. and Mrs. Paul R. Tindall, on Flat Rock. A brief business session was also held.

Whitley County Medical Society members met at Whitley County Memorial Hospital on June 17. Dr. Ernest V. Nolt, of Columbia City, showed a film on "Nursing Care In Poliomyelitis." Twenty-four members and guests were present.

### WOMAN'S AUXILIARY

to the

Indiana State Medical Association

President—Mrs. Hubert T. Goodman, Terre Haute

President-Elect—Mrs. Burleigh Matthew, Indianapolis

Corresponding Secretary—Mrs. B. M. Merrell, Rockville

Recording Secretary—Mrs. Charles Richardson, Rochester

Treasurer—Mrs. J. M. Sullivan, Terre Haute

Publicity—Mrs. F. M. Gastineau, Indianapolis

The Woman's Auxiliary to the American Medical Association held its twenty-ninth annual session in Chicago, June 9 to 13. Registration began Sunday, June 8, in the Grand Ballroom Foyer of the Conrad Hilton Hotel, Auxiliary headquarters.

Pre-convention committee meetings were held on Sunday and concluded Monday. Round table discussions on Program, Legislation, Public Relations and *Today's Health*, moderated by the respective national chairmen, were conducted Monday. Dr. Frank Wilson, deputy director of the Washington office, presented valuable information at the Legislative discussion.

Preceding the formal opening of the House of Delegates Tuesday morning, Mrs. Francis M. Fargher, immediate past president, was hostess to the Indiana delegates for an informal breakfast. The following Auxiliary members and the counties they represent, were present: Mrs. Fargher, LaPorte; Mrs. Robert Rang, Daviess; Mrs. Richard Stout, Elkhart; Mrs. Harvey Bowers and Mrs. Arthur E. Stinson, Fulton; Mrs. Wallace Grayston and Mrs. Claude Black, Huntington; Mrs. Ray Elledge, Mrs. Milton Gevitz, Mrs. J. W. Gustaitis, Mrs. J. W. Mather and Mrs. F. M. Young, Lake; Mrs. Lester Bibler and Mrs. Frank Gastineau, Marion; Mrs. W. L. Dalton and Mrs. William Tindall, Shelby; Mrs. Paul Steele, Vanderburgh; Mrs. Hubert T. Goodman and Mrs. Robert Schumaker, Vigo; Mrs. Truman E. Caylor and Mrs. Jack Eisaman, Wells.

Routine business was conducted at the sessions held Tuesday, Wednesday and Thursday morning. Mrs. Fargher served as a timekeeper and represented Indiana most ably when she gave her brief but concise report of Indiana's achievements for the 1951-52 year.

Miss Emily Cardew, president of the Illinois State League of Nursing Education, spoke at the Tuesday afternoon session on nurse recruitment, which she described as a problem too big for the nursing profession and one in which we, as doctors' wives, have a stake. Dr. John W. Cline, retiring president of the American Medical Association, addressed the House of Delegates briefly



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on Wednesday morning, again emphasizing that we are in a critical period and urging us to act before it is too late.

Highlights of the business meetings were: acceptance of recommendations of the Board of Directors that the Woman's Auxiliary to the American Medical Association contribute \$10,000 to the American Medical Education Foundation and \$500 to the World Medical Association. Among recommendations presented by the Resolutions Committee and adopted were those urging the continuation of the Civil Defense Committee so long as there is need for it; continued active participation of auxiliary members in Blood Donor programs; renewed efforts in behalf of nurse recruitment and aid to practical nursing program. The meeting was concluded Thursday morning with the election and installation of officers, at which time Mrs. Eusden assumed the duties of President. Nine hundred and twenty-four National Board members, delegates, alternates, members and guests were registered for the convention.

Indiana received recognition by the election of Mrs. Francis M. Fargher, Michigan City, to the 1952-53 nominating committee and the appointment of Mrs. Frank Gastineau, Indianapolis, as chairman of the newly approved American Medical Education Foundation Committee.

Social events of the convention were outstanding. The Woman's Auxiliaries to the Illinois State and Chicago Medical Societies were hostesses for a Fashion Tea Monday afternoon in Marshall Fields' Narcissus Room. Mrs. Harold F. Wahlquist, president, and Mrs. Ralph Eusden, president-elect, were honor guests. All physicians' wives were invited and every guest received a carnation corsage. Delicious refreshments were served while attractive models displayed beautiful summer fashions.

The Tuesday luncheon, with Mrs. Wahlquist presiding, was held in the Boulevard Room of the Conrad Hilton and honored past presidents of the Woman's Auxiliary to the American Medical Association. Dr. Laurence M. Gould, President, Carleton College, Northfield, Minn., was guest speaker.

Mrs. Frank Haggard, a former National President, presided at the Wednesday Luncheon in the Boulevard Room, honoring Mrs. Wahlquist and Mrs. Eusden. Dr. John W. Cline, retiring President, Dr. Louis H. Bauer, President, and other officials of the American Medical Association were guests of honor. Dr. Bauer spoke briefly, complimenting the Auxiliary on the work accomplished, enlisted continued support for the Education Foundation, saying that this in itself justifies our existence. Dr. Bauer acknowledged the \$10,000 contribution of the auxiliary to this fund.

Final social event of the meeting was the 30th La Hoomanao Lulau (Anniversary Dinner) sponsored by the United Air Lines, held in the Crystal Ballroom of the Blackstone Hotel, Thursday night at 7:00. Decorations flown in from Hawaii, leis of baby orchids for the honor guests and committee members, table decorations of pineapples cov-

ered with baby orchids and paper leis for the women guests lent a tropical atmosphere to the excellent dinner enjoyed by approximately 500 Auxiliary members and guests. The 30th birthday cake was cut by Mrs. Wahlquist and Mrs. Eusden. Mrs. Fargher scored again when her number was drawn and she received a First Aid Kit. Following the dinner, a ball was held at the Palmer House in honor of Dr. Louis Bauer, newly installed president of the American Medical Association.

## INDIANA STATE BOARD OF HEALTH

### Division of Communicable Disease Control

#### MONTHLY REPORT—APRIL 1952

Disease	Apr. 1952	Mar. 1952	Feb. 1952	Apr. 1951	Apr. 1950
Chickenpox	266	420	605	224	346
Diphtheria	3	8	3	9	22
Influenza	11	2681	1105	20	37
Infectious hepatitis	19	40	49	11	5
Malaria	2	0	0	0	0
Measles	1752	1876	951	705	1734
Meningitis,					
Meningococcal	4	5	4	4	10
Unclassified	4	14	9	7	4
Tubercular	1	0	0	0	0
Mumps	462	731	660	225	132
Pneumonia	42	73	41	52	122
Poliomyelitis	1	1	6	2	2
Rabies in animals	22	26	12	49	70
Rubella	138	109	67	287	58
Scarlet fever	146	299	409	207	268
Tinea capitis	3	0	2	4	0
Typhoid fever	2	1	3	0	1
Vincent's angina	1	2	4	1	2
Whooping cough	34	21	34	51	188

#### MONTHLY REPORT—MAY 1952

Disease	May 1952	Apr. 1952	Mar. 1952	May 1951	May 1950
Brucellosis	4	0	0	0	2
Chickenpox	356	266	420	156	279
Diarrhea	3	0	2	0	0
Diphtheria	9	3	8	6	13
Dysentery,					
Amoebic	3	0	3	0	0
Shigella	1	0	0	0	0
Encephalitis	5	0	6	3	1
Food infection	1	0	0	3	3
Impetigo	1	0	0	5	3
Influenza	9	11	2681	38	6
Infectious hepatitis	21	19	40	9	1
Malaria (military)	9	2	0	0	0
Measles	2000	1752	1876	648	2244
Meningitis,					
Meningococcal	12	4	5	2	4
Unclassified	3	4	14	6	2
Lymphocytic chorea	1	0	0	0	0
Mumps	529	462	731	292	125
Pneumonia	64	42	73	44	20
Poliomyelitis	5	1	1	1	3
Rabies	14	22	26	58	52
Rheumatic fever	7	0	3	5	0
Rubella	218	138	109	216	83
Scarlet fever	176	146	299	102	170
Tetanus	1	0	0	1	2
Tinea capitis	1	3	0	0	21
Typhoid fever	2	2	1	2	1
Whooping cough	29	34	21	135	176
Psittacosis	1	0	0	0	1



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## BOOK REVIEWS

**STANDARD NOMENCLATURE OF DISEASES AND OPERATIONS.** American Medical Association, edited by Richard J. Plunkett, M.D., editor, and Adaline C. Hayden, R. R. L., associate editor. Fourth Edition. 1,034 pages and 4 illustrations. Price \$8.00. The Blakiston Company, Philadelphia 5, Penna., 1952.

The first edition of this book which was prepared by the National Conference on Nomenclature of Disease was published in 1933, a second edition appeared in 1935. It then became obvious that a medical nomenclature must be kept constantly abreast of medical progress and in 1937 the A.M.A. assumed the responsibility of its periodic revision. A third edition was published under the direction of the A.M.A. in 1942. The editors have spent three years preparing this edition.

In this, the fourth edition, the title has been changed from "Standard Nomenclature of Disease and Standard Nomenclature of Operations" to the "Standard Nomenclature of Diseases and Operations." Numerous changes have been made in the general arrangement of this edition that have enhanced its usefulness. Obviously the growth of scientific knowledge has required many changes in medical terminology. The most important revisions have been made in the sections dealing with psychiatric disorders, diseases of the "Hemic and Lymphatic" Systems" and "Tumor" diagnosis.

This edition includes every disease which is clinically recognizable and every surgical procedure with as little repetition and overlapping as possible; nondiagnostic terms are also included. Diseases are divided into two general classifications; topographic and etiologic. There is also a complete index of diseases and operations. The International Statistical Classification is included and correlated to the Standard Nomenclature in the Appendix. The complete volume is thumb-indexed which increases its usefulness for rapid reference.

In the preparation of the work the editors procured the assistance of committees made up of outstanding authorities in every branch of medicine. The chairmen of these committees were empowered to appoint additional consultants and to collaborate fully with other national medical and scientific associations.

This work has been well received by medical record librarians and they appear to be able to master the coding system without serious difficulty. It is essential to have a copy of the book in every hospital record library and it should be available and used by physicians and interns in writing medical records. This nomenclature should also be referred to and its terminology used by everyone who does medical writing.

D. A. B.

**PRINCIPLES AND PRACTICE OF OBSTETRICS:**

By J. P. Greenhill, M.D., Attending Obstetrician and Gynecologist, The Michael Reese Hospital; Obstetrician and Gynecologist, Associate Staff, The Chicago Lying-In Hospital; Attending Gynecologist, Cook County Hospital; Professor of Gynecology, Cook County Graduate School of Medicine. New, 10th Edition. 1020 pages, with 1140 illustrations on 864 figures, 194 in color. Philadelphia and London: W. B. Saunders Company, 1951. Price \$12.00.

This is indeed a heavy tome—a full five pounds by actual weight—unusual nowadays—and perhaps the good paper explains some of the excellence of the typography, especially the illustrations. This being the tenth edition of an old, trusted, obstetrical text, and guide to student and practitioner alike, it is fitting to mention Doctor Greenhill's statement that he has "practically rewritten the entire book."

As noted in reviewing Titus' work on management of obstetrical difficulties, the Drs. Greenhill, N. J. Eastman, Paul Titus and Charles O. McCormick all met in 1950 and agreed on a simpler classification of toxemias of pregnancy; on classification of breech presentations and their methods of delivery; on definitions of engagement and station; and on definition of low, mid-, and high-forceps procedures. They further agreed that external caliper mensuration of the pelvic inlet is of no value, and that it should be abandoned. However, a brief discussion of the interspinous, intercrystal, intertrochanteric and Baudelocque's diameters is retained because "these measurements are still required on antepartum records of many hospitals and some special societies."

The classification of toxemias is as follows:

- I. Acute Toxemias of Pregnancy
  - a. Preeclampsia
  - b. Eclampsia
- II. Chronic Hypertensive Vascular Disease (Essential Hypertension)
  - a. Without superimposed acute toxemia
  - b. With superimposed acute toxemia.

This book is voluminous (68 chapters) yet easy to read (on account of good typography), easy to comprehend (owing to good diction), and easy to use as a reference (good index). These factors explain the popularity of this work among the profession. New material has been added to this edition on many subjects, including new data, or opinions, on physiology of the uterus, on the lower uterine segment, on roentgen studies, on anesthesia and analgesia, on toxemias and their follow-up investigation, on definition of prematurity, on threatened and habitual abortion, on treatment of placenta previa and abruptio placentae, on German measles, and the like, in early pregnancy, on cardiac disease in pregnancy, on erythroblastosis fetalis, on constriction ring and related conditions, on shock in obstetrics and on the newer drugs and antibiotics. In all, it is a well prepared book.

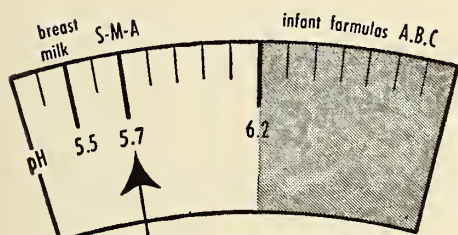


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### REFERENCES

1. Barbero, G.J., Runge, G., Fischer, D., Crawford, M.N., Torres, F. E., and Gyorgy, P.: J. Pediat. 40:152 (Feb.) 1952.
2. Watson, J.: Gordon Research Conf. Vitamins and Metabolism, 1950.
3. Torres, F.E., Romans, I.B., and Wheller, J.B.: A Study of Infantile Diaper Rash. To be published.



## BOOK REVIEWS

**PSYCHOSOMATIC GYNECOLOGY:** Including Problems of Obstetrical Care. By William S. Kroger, M.D., Assistant Clinical Professor of Obstetrics and Gynecology, Chicago Medical School; and S. Charles Freed, M.D., Adjunct in Medicine, Mount Zion Hospital, San Francisco, California. 503 pages, price \$8.00. W. B. Saunders Company, Philadelphia 5, Pa., 1951.

The recent recognition of the importance of psychosomatic factors in illness has resulted in voluminous literature on the subject. Many of the books which have been written are worth reading and retaining for reference, while many others are repetitious and contribute but little to medical literature. This book is intended to coordinate the specialties of psychiatry and gynecology.

The authors have thoroughly considered the psychosomatic factors involved in the more common gynecologic complaints and also in problems of obstetrical care. It is a rather extensive work consisting of 495 pages without any illustrations or charts. Gynecologic and psychiatric forewords are written by outstanding authorities in the two specialties: J. J. Greenhill and Flanders Dunbar.

The first chapter, dealing with maternal fetal relationship, no doubt will appear to most readers to expound some very speculative ideas; especially some of the material dealing with fetal emotions. The authors give some credence to the old notion of prenatal influences.

The chapter on the psychosomatic aspects of pregnancy is written by Grantly Dick Read and most of the ideas he expresses here are those put forth in his own works on natural childbirth, which have not been wholly accepted by obstetricians in this country. This does not mean that Read's works are without merit, for they have contributed enormously to the psychological management of labor.

Most obstetricians will agree with the authors regarding the psychogenic factor in the nausea and vomiting of pregnancy. It is unfortunate that this fact is not generally appreciated by the medical profession, and that patients are not treated by some superficial psychotherapy instead of expensive and useless vitamins, hormones and antihistamines. The authors seem to have some difficulty in postulating a psychosomatic factor in the etiology of pre-eclamptic toxemia.

A lengthy discussion is devoted to hypnosis in labor and it is given limited recommendation. It is to be remembered that hypnosis was attempted in surgery many years before anesthetics were discovered. If it had any value comparable to modern anesthesia it is unlikely that it would have been discarded.

In general, the ideas expressed by the authors are factual and they have presented much essential knowledge to physicians who treat women. And if the psychosomatic factors in gynecology were more

generally appreciated much useless surgery and medical treatment would be avoided. When dealing with a subject about which there is so much more to be learned the authors must necessarily engage in considerable speculation, and some physician readers will not have the perseverance to wade through its verbosity.

The book is well indexed and every chapter concludes with an extensive bibliography. It is recommended to obstetricians, gynecologists, psychiatrists and all physicians who treat women patients.

D. A. B.

**DYNAMIC PSYCHIATRY, Basic Principles Volume I.**

By Louis S. London, M.D., Cloth \$2.00. Pages 95, Corinthian Publications, Inc., New York 16, New York 1952.

In the first half of this small volume the author presents a historical review of medicine with emphasis on the evolution of psychotherapeutics. Beginning in mythologic past when symptoms of disease were ascribed to supernatural influences, he follows through the centuries of primitive cultures to the golden ages of medicine in the Pythagorean school, Asclepiades, Hippocrates, and Galen. Much is said of the early Hebrew concepts of mental diseases, scripture references being made frequently. A third era during the Dark Ages, with religious domination of scientific thought and a return to superstition, fear, and demonology, is discussed, with its import on the medical thoughts of the day. The last phase of historical evolution starts with the 17th Century up to Freud.

In presenting this historical material, the author draws heavily from other historians of psychiatry whose works are more comprehensive. Proper acknowledgment is made and a detailed bibliography is added for reference.

For this reviewer, the chief value of the remainder of the book lies in the few pages that explain the language of the dream as being a picture code. He emphasizes the manifest content of dreams as distinguished from the latent content, the anxiety forces that cause one to awaken during sleep, and the methods of free association; all concepts in keeping with Freudian theories.

The rest of the book is confusing. The author deals with basic principles of definition of the libido according to what dictionaries say and to what interpretations various writers as Freud, Jung, Abraham, Hermann, Starke, Eisler, Sadger, Searl, Talme, etc., have made concerning the development of the libido and its relation to theories as of the oedipus complex, electra complex, ambivalence, the castration complex, and various nervous disorders. None of these concepts are explained at a basic level. Unless one is already well schooled in Freudian psychoanalytic language and concepts, the material as presented merely bewilders the reader as to what the subject matter is all about. The fault seems to be that the author presupposes the theories discussed are already understood and accepted by the reader. Some who read the book might wish that there were a logical progression of ideas which would prepare him to accept the theories offered.

T.M.C.



## Books

Books received are acknowledged in this column, and such acknowledgment must be regarded as a sufficient return for the courtesy of the sender. Selections will be made for more extensive review in the interests of our readers and as space permits. Books listed in this department are not available for lending. Any information concerning them will be supplied on request.

### BOOKS RECEIVED

**THE SCALP IN HEALTH AND DISEASE.** By Howard T. Behrman, M.D., Assistant Clinical Professor of Dermatology, New York University Post-Graduate Medical School. 566 pages with 312 illustrations, price \$12.75. The C. V. Mosby Company, 3207 Washington Blvd., St. Louis 3, Missouri. 1952.

**TOXEMIAS OF PREGNANCY. Second Edition.** By William J. Dieckmann, M.D., Mary Campau Ryerson Professor and Chairman of the Department of Obstetrics and Gynecology of the University of Chicago; Associate Editor of the American Journal of Obstetrics and Gynecology. 710 pages and 85 text illustrations, with one color plate. Price \$14.50. The C. V. Mosby Company, 3207 Washington Blvd., St. Louis 3, Missouri. 1952.

**PRINCIPLES OF REFRACTION.** By Sylvester Judd Beach, M.D., Consultant, Staff, Maine Eye and Ear Infirmary and Chief Ophthalmologist, Portland City Hospital. 158 pages, price \$4.00. The C. V. Mosby Company, 3207 Washington Blvd., St. Louis 3, Missouri. 1952.

**BONE TUMORS.** By Louis Lichtenstein, M.D., Senior Pathologist, General Medical and Surgical Hospital Veterans Administration Center, Los Angeles; formerly Associate Pathologist, Hospital for Joint Diseases, New York. 315 pages, with 155 illustrations. Price \$10.50. The C. V. Mosby Company, 3207 Washington Blvd., St. Louis 3, Missouri. 1952.

**BACITRACIN.** A review and digest of the literature up to and including January 1952. 127 pages. Price \$4.00. Research Division of S. B. Penick & Company, 50 Church St., New York. 1952.

**THE ORIGIN OF LIFE AND THE EVOLUTION OF LIVING THINGS. An Environmental Theory.** By Olan R. Hyndman, M.D. Prepared in five sections, 648 pages. Price \$8.75. The Philosophical Library, 15 E. 40th St., New York 16, N. Y. 1952.

**THE FIGHT AGAINST TUBERCULOSIS.** An autobiography by Francis Marion Pottenger, M.D., with an introduction by Roy G. Hoskins, M.D. 276 pages. Price \$4.00. Henry Schuman, Inc., 20 E. 70th St., New York 21, N. Y. 1952.

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Gallbladder Surgery, Ten Hours, starting October 20.  
Basic Principles in General Surgery, Two Weeks, starting September 8.  
General Surgery, One Week, starting October 6.  
General Surgery, Two Weeks, starting October 6.  
Breast & Thyroid Surgery, One Week, starting October 6.  
Esophageal Surgery, One Week, starting October 13.  
Thoracic Surgery, One Week, starting October 20.  
Fractures & Traumatic Surgery, Two Weeks, starting October 6.

**GYNECOLOGY**—Intensive Course, Two Weeks, starting September 8, October 20.  
Vaginal Approach to Pelvic Surgery, One Week, starting September 22, November 3.

**OBSTETRICS**—Intensive Course, Two Weeks, starting September 29, November 3.

**MEDICINE**—Electrocardiography & Heart Disease, Two Weeks, starting September 29.  
Intensive General Course, Two Weeks, starting October 13.  
Gastroscopy & Gastroenterology, Two Weeks, starting September 15, November 3.

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## BOOKS

## BOOKS RECEIVED

**SURGICAL GYNECOLOGY—Including Important Obstetric Operations.** By J. P. Greenhill, M.D., Professor of Gynecology, Cook County Graduate School of Medicine; Attending Gynecologist, Cook County Hospital; Attending Obstetrician and Gynecologist, Michael Reese Hospital. 350 pages, 101 plates with detailed drawings. Price \$8.50. Year Book Publishers, Inc., 200 E. Illinois St., Chicago 11, Ill. 1952.

**LIVING IN BALANCE.** By Frank S. Caprio, M.D., internationally recognized authority in fields of psychiatry and psychoanalysis. 246 pages. Price \$3.75. The Arundel Press, Inc., Washington 13, D. C. 1951.

**DYNAMIC PSYCHIATRY. Volume Two. Transvestism—Desire for Crippled Women.** By Louis S. London, M.D., formerly associated with several of the largest mental hospitals in New York State, followed by several years of intensive post-graduate study in Vienna. 127 pages, 50 figures. Price \$2.50. Corinthian Publications, Inc., New York 16, N. Y. 1952.

**THE STORY OF THE ADAPTATION SYNDROME.** By Hans Selye, M.D., Ph.D., Professor and Director of the Institut de Médecine et de Chirurgie expérimentales Université de Montréal. 225 pages. Price \$4.50. Acta, Inc., Medical Publishers, Montreal, Canada. 1952.

**ELEMENTARY MEDICAL STATISTICS—The Principles of Quantitative Medicine.** By Donald Mainland, M.D., Professor of Medical Statistics, the Department of Preventive Medicine, New York University College of Medicine. 327 pages with 23 figures. Price \$5.00. W. B. Saunders Company, W. Washington Square, Philadelphia 5, Pa. 1952.

**ADVANCES IN MEDICINE AND SURGERY: from the Graduate School of Medicine of the University of Pennsylvania.** By an editorial committee, Julius H. Comroe, Jr., Chairman. 441 pages with 43 figures. Price \$8.00. W. B. Saunders Company, W. Washington Square, Philadelphia 5, Pa. 1952.

**SURGERY AND THE ENDOCRINE SYSTEM.** Physiologic Response to Surgical Trauma—Operative Management of Endocrine Dysfunction. By James D. Hardy, M.D., Assistant Professor of Surgery, University of Tennessee Medical College. 153 pages with 43 figures. Price \$5.00. William B. Saunders Company, W. Washington Square, Philadelphia 5, Pa. 1952.

**A TEXTBOOK OF PHARMACOLOGY—Principles and Application of Pharmacology to the Practice of Medicine.** By William T. Salter, M.D., Professor of Pharmacology, Yale University School of Medicine. 1,240 pages with 284 figures. Price \$15.00. W. B. Saunders Company, W. Washington Square, Philadelphia 5, Pa. 1952.

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# *Opinions From Here and There*

**Prepared for your Information by the Committee on Public Policy and  
Legislation of the Indiana State Medical Association**

## **What the National Candidates Have to Say About National Health Insurance**

In response to requests for information concerning the attitude of General Eisenhower, Governor Stevenson, Senator Nixon and Senator Sparkman on the issue of National Compulsory Health Insurance, Whitaker and Baxter have supplied the following statements which have been made by these candidates. The statements thus far available are in some instances ambiguous, but it is assumed that as the campaign develops the several candidates will speak out more specifically on the issue of Compulsory Health Insurance. We are sure you would like the opportunity to read and compare the statements made to this time. They are as follows:

### **Statement on Health Insurance by General Dwight D. Eisenhower, Republican Nominee for President**

At his press conference in Abilene, Kansas, on June 5, 1952, General Eisenhower was asked the question: "Are you for Compulsory Health Insurance?"

Here is General Eisenhower's reply:

"I am not going to answer too specifically, because what could be in a bill labeled compulsory health insurance, I am not so certain. But I can tell you this: I am quite certain over the years that I was at Columbia, no one spoke out more than I did against the centralization of power in Washington, against bureaucratic government and submitting our lives toward a control that would lead inevitably to socialism. . . . I do believe that every American has a right to decent medical care."

In discussing Federal aid to medical education, General Eisenhower said that in private universities we must ". . . support medical education by private means, because if we didn't it would be the first step toward the socialization of medicine, and I am against socialization."

### **Statement on Health Insurance by Governor Adlai Stevenson of Illinois, Democratic Nominee for President**

"I am against the socialization of the practice of medicine as much as I would be against the socialization of my own profession, the law. . . . If the insurance principle could be brought to bear on these catastrophic

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illnesses, it would largely eliminate the specter of terror from the average home. . . . I am sure that . . . the common objective can be largely realized without the destruction of professional independence.

"Basically, the problem is how to lift people over the costs of major illness. I don't know whether voluntary plans can do the job." I think the new commission on medical needs may well add some light and remove some heat, enabling us to find a satisfactory solution to this perplexing problem."

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In a press conference on July 30, 1952, Governor Stevenson was asked "whether he saw eye to eye with Federal Security Administrator Oscar Ewing" on the issue of Compulsory Health Insurance.

Governor Stevenson's reply to this question was as follows:

"No, on a number of occasions in the past I have indicated that I thought a new approach was necessary. I emphatically believe that we must find some solution to the problem of catastrophic illness and its devastating expense.

"The President's Commission, of which my friend, Dr. Paul B. Magnuson, is Chairman, might well come up with some recommendations and suggestions which would be more palatable, and I am hopefully awaiting the result of the deliberations."

\* \* \* \* \*

**Statement on Health Insurance by U. S. Senator Richard M. Nixon,  
Republican Nominee for Vice President**

(Excerpts from address delivered before the seventh annual meeting, Conference of Presidents and Other Officers of State Medical Associations, Atlantic City, June 10, 1951.)

"I would like . . . to express my congratulations to the members of this group, and to the medical profession generally, for the very splendid political action the medical profession took in the last campaign leading up to the November election, and in other previous campaigns. As a result of that action, I think we can safely say that . . . there is no chance whatever at this time for any type of compulsory health insurance program to be enacted. . . . On the other hand, I think you must recognize, *and that all of us who are interested in this fight must recognize*, that those who favor such legislation will continue to work fanatically for their cause, in

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the hope that somehow, sometime in the future, they will be able to accomplish their purpose.

"I think . . . that a great number of people, probably a majority of the people in the country, are convinced that the compulsory health insurance programs which sound so good in theory have not worked out in action in those nations which have tried them.

"I am convinced that the medical profession has taken a very long step in the right direction with its recently announced program of subsidizing medical schools on a voluntary rather than on a government basis. I would suggest also that additional voluntary action is needed (in dealing with) the problem of encouraging wherever possible voluntary health insurance programs. *It seems to me that the objective toward which we should work in the United States is a system where eventually anybody who wants health insurance can get it—where those who should have health insurance are encouraged to get it—but where no one in the United States is compelled to take out such insurance against his will.* If the profession adopts that objective we will remove by voluntary action the strongest arguments that the proponents of government control of the medical profession have at the present time.

"I believe it is essential that all members of the medical profession recognize that an attempt to socialize any American profession—any American institution—constitutes a threat to all.

"Traditionally, the great accomplishments in this country have not been through government action, but through individual and cooperative action. . . . (Our task) is by precept and by example, to prove to the people of the world that a free people, working as individuals, working cooperatively, can solve the problems of our society and can solve them more effectively than can a government."

**Statement on Health Insurance by U. S. Senator John J. Sparkman,  
Democratic Nominee for Vice President**

"I am in favor of adequate medical attention for the people of this country. However, I have not favored what is generally known as Socialized Medicine.

"I would be opposed to any plan which I thought would, in effect, socialize medicine, and to any medical program which would destroy the relationship of doctor and patient."

The foregoing statement was made by Senator Sparkman in an interview with Mr. Al Goldsmith, editor of *Washington Insurance Newsletter*, on July 31, 1952.

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*Washington Insurance Newsletter* reported that Senator Sparkman strongly indicated he was opposed to the Truman National Compulsory Health Insurance Program, but declined to take a position on specific bills now before the Congress.

In 1949, when the roll was called in the U.S. Senate on President Truman's Reorganization Plan No. 1, which would have created a Department of Welfare, Senator Sparkman stood with medicine in opposition to this scheme to give Federal Security Administrator Oscar Ewing cabinet status, with increased power over the health and medical affairs of the country.

**DEMOCRAT HEALTH PLANK**—The Democrats adopted an anemic health plank in comparison with the Republican plank printed on this page last month. It is interesting to note the plank, as adopted in Chicago, July 23, is considerably more moderate than the position taken by President Truman, and is also more moderate than the party's previous position, but it does pay indirect tribute to the effectiveness of the physicians' crusade against Socialized Medicine, in that it seeks to remove the issue from consideration during the forthcoming Presidential and Congressional election campaigns. The plank as adopted is as follows:

We will continue to work for better health for every American, especially our children. We pledge continued and wholehearted support for the campaign that modern medicine is waging against mental illness, cancer, heart disease and other diseases.

*Research:* We favor continued and vigorous support, from private and public sources, of research into the causes, prevention and cure of disease.

*Medical Education:* We advocate federal aid for medical education to help overcome the growing shortages of doctors, nurses, and other trained health personnel.

*Hospitals and Health Centers:* We pledge continued support for federal aid to hospital construction. We pledge increased federal aid to promote public health through preventive programs and health services, especially in rural areas.

*Cost of Medical Care:* We also advocate a resolute attack on the heavy financial hazard of serious illness. We recognize that the costs of modern medical care have grown to be prohibitive for many millions of people. We commend President Truman for establishing the non-partisan commission on the health needs of the nation to seek an acceptable solution of this urgent problem.

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### THE TREATMENT OF CONGESTIVE HEART FAILURE†

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*Cincinnati, Ohio*

**I**N CONSIDERING the patient suffering from congestive heart failure one should decide first of all into which of two great groups the patient belongs: (1) those with potentially curable heart failure, and (2) those with heart failure which can be greatly ameliorated but in whom the underlying cause is at present irreversible. Our primary concern in this discussion is with the second of these two categories; however, we will begin by discussing the first group briefly.

#### I

Although the first group is seen less frequently it is extremely important that it be recognized. The patient may be restored to complete health by removing the etiological

factor. Further, his response to the measures which are to be outlined for the second group will usually be unsatisfactory although some improvement will in all likelihood be noted. Patients with potentially curable heart failure may be divided into the following eight groups: (1) thyrotoxicosis, (2) systemic arteriovenous fistula, (3) anemia, (4) beriberi, (5) constrictive pericarditis, (6) myxedema, (7) paroxysmal arrhythmia, e.g. auricular fibrillation, paroxysmal ventricular tachycardia, (8) congenital heart disease. We will now discuss each of these classifications briefly.

1. Thyrotoxicosis alone uncommonly produces congestive heart failure, there usually being some other reason as well.<sup>1</sup> However, cure of the thyrotoxicosis may enable the patient to live a normal life and the underlying heart disease may remain latent. The diagnosis of thyrotoxicosis with heart failure

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†Presented at postgraduate meeting of the Indiana Academy of General Practice at Rushville, on January 9, 1952.

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may be obvious. The patient may present all the classic signs of thyrotoxicosis: stare, exophthalmos, goiter, tachycardia, tremor, and warm smooth skin. On the other hand, the diagnosis may be very difficult if the patient is a so-called "masked thyrocardiac." One may suspect thyrotoxicosis when the patient with congestive heart failure is not lethargic but is alert and responds quickly to questions. Paroxysmal auricular fibrillation may also be a clue to the diagnosis. The diagnosis by measurement of the basal metabolism may be unreliable, especially if the patient is dyspneic. One may need to rely upon serum precipitable iodine levels or upon the percentage uptake of a tracer dose of 50 or 100 microcuries of radioactive iodine. At times observation of the response of the patient to a therapeutic test may be necessary.

2. Systemic arteriovenous fistula is usually readily apparent when a continuous thrill and murmur are discovered over the course of peripheral vessels and may be either congenital or traumatic. Congestive heart failure does not usually result from systemic arteriovenous fistula unless the fistula is quite large. When this occurs, removal of the fistula may result in the return of the heart to normal size and function.

3. Anemia alone rarely results in congestive heart failure unless the hemoglobin of the blood is at a very low level—usually in the neighborhood of 3.5 grams per 100 cc. of blood.<sup>2</sup> It, however, may be an aggravating factor in heart failure due to other causes. If anemia in a patient with congestive heart failure is treated by transfusion it is better to give 200 to 300 cc. of blood at a time rather than large quantities.

4. Beriberi is seen in patients whose diet has been deficient in liver, meat and whole grain cereals, or other sources of thiamine, for three months or more. In our experience it is seen chiefly in chronic alcoholics, in demented persons, in food faddists and in individuals who live alone and do their own cooking. Beriberi as a cause of heart failure may be suspected in an individual who gives a history of such a deficient diet for three months or more, who has other signs of vitamin deficiency such as peripheral neuritis, pellagrous dermatitis or stomatitis, who has

evidence of elevation of the venous pressure, cardiac enlargement with sinus rhythm, who has a wide pulse pressure in the systemic arteries with Corrigan pulse, warm skin and often a pistol shot sound over the peripheral arteries.<sup>3</sup> The electrocardiogram in such individuals shows but minimal abnormality. The circulation time measured with decholin is often normal or rapid. In doubtful cases the evaluation of the therapeutic response to thiamine may be definitive. Although thiamine is the specific therapy for this condition, in cases of long standing the classical response may no longer be observed.

5. Constrictive pericarditis is a cause of the congestive failure syndrome and should be suspected in an individual who does not respond in the usual manner to the conventional treatment of congestive heart failure, who has persistent elevation of his venous pressure, a heart of normal size or with only moderate enlargement and who has a paradoxical pulse of 10 mm. mercury or more in his peripheral arteries. The diagnosis is strengthened by fluoroscopic observation of the markedly diminished or absent pulsations of the heart and by low voltage of the QRS complex and T waves in the electrocardiogram. Calcification in the pericardium may be observed in one-third of the cases.<sup>4</sup> Surgical stripping of the constricting pericardial scar may be curative.

6. Although myxedema very rarely produces typical congestive heart failure,<sup>5</sup> it may, by producing an accumulation of pericardial fluid, mimic heart disease of other types. The diagnosis can readily be made by physical examination of the patient if it is considered.

7. Paroxysmal arrhythmias, which increase the ventricular rate by shortening of the diastolic filling period of the heart and thus diminishing cardiac output, may give rise to congestive heart failure. This occurs more commonly in individuals who have already some diminution in cardiac reserve but may occur occasionally in individuals with normal hearts. Auricular fibrillation and ventricular tachycardia are two of the worst offenders in this regard. The reversion of these arrhythmias to normal sinus rhythm with quinidine may result in a return to cardiac compensation. Normal individuals may have auricular



fibrillation and be greatly improved following the restoration of sinus rhythm by quinidine.<sup>6</sup>

8. At the present time there are only a few types of congenital heart disease for which specific operative treatment can be offered. However, the number of operations for such conditions is being increased rapidly. Perhaps the foremost example of a congenital condition which may lead to congestive failure, and which is completely curable by operation is patent ductus arteriosus. Since the life expectancy in this condition, if the patient reaches the age of 17, is only  $\frac{1}{2}$  of normal, it is our present feeling that all such patients below the age of 35 should have the ductus divided. The ideal age for this operation is between 5 and 15.<sup>7</sup> Coarctation of the aorta is another congenital condition curable by operation, and should be suspected in a young individual with hypertension and left ventricular enlargement whose blood pressure in the lower extremities is below that in his upper extremities. Other congenital conditions which can be greatly improved surgically, though not cured, are tetralogy of Fallot, isolated pulmonic stenosis, and tricuspid atresia.

Although operations upon stenotic mitral and aortic valves are being done, discussion of these is beyond the scope of this paper.

## II

We will now consider management of the second group of patients, namely, those who have congestive heart failure associated with an etiology which is at the present time not remediable; for example, congestive heart failure due to hypertension, coronary artery disease and valvular disease. There are six factors which are important in the routine management of the failing heart. These are (1) rest, (2) the use of digitalis, (3) sodium restriction, (4) proper fluid intake, (5) the use of diuretics, (6) careful observation of the patient's weight. These factors will now be considered singly.

### Rest

Rest is very important in the management of congestive heart failure although it may be overdone. The patient with congestive heart failure is often greatly benefited by a

few weeks of rest. Unless bed rest is absolutely necessary the patient's rest is best accomplished in a chair. He should not be confined absolutely to bed unless extremely dyspneic, or extreme pain or mental confusion occurs. If the patient is placed in bed the recumbent position should be avoided.

The advantages of rest are as follows: The cardiac output which is usually inadequate for the individual's requirements during activity may become sufficient when he is at rest. As a consequence of this his renal blood flow may also become adequate and he may be able to lose considerable quantities of retained sodium and water. The venous pressure is lower at rest and may even return to normal. Rest also lowers the systemic blood pressure and peripheral resistance, thus decreasing the work of the heart. Also, the cardiac rate is slowed, thus giving more time for diastolic filling and improving of cardiac output.

Complete recumbency, however, may have undesirable effects. Among these are the following: Recumbency tends to increase the blood flow, thereby increasing the work of the heart. It may cause a shift of fluid to the lungs, thereby lowering the vital capacity. Circulation time is prolonged. The patient often has difficulty in urination and defecation. The danger of pulmonary embolism, already present in congestive failure, is increased both by stagnation of the flow of blood in the peripheral veins and by straining upon the bed pan. Absolute bed rest may also lead to atelectasis of the lungs and hypostatic pneumonia, decubitis ulcers, and negative calcium and nitrogen balance.

### The Use of Digitalis

Other than rest, digitalis is one measure which is also indicated in the routine management of the failing heart. There are a large number of potent preparations of digitalis but it is better to become familiar with one or two than to have a superficial knowledge of the entire group. All potent preparations of digitalis are also potentially toxic. Digitalis should be given orally unless there is a dire emergency or unless the patient is unable to take an oral medication. The two preparations of digitalis which are most commonly

used are the whole leaf and digitoxin. Because of its instability we prefer to avoid the tincture of digitalis. Digitoxin has roughly 1000 times the potency of the whole leaf so its dosage is roughly 1/1000 of the whole leaf. The average digitalizing dose of the digitalis leaf is 1.2 grams with a range of 1 to 1.5 grams. The average daily maintenance dose of digitalis leaf is 0.1 of a gram with a range of 0.05 to 0.2 of a gram. The average digitalizing dose of digitoxin is 1.2 mg. with a range of 1.0 to 1.8 mg. The average daily maintenance dose of digitoxin is 0.15 mg. with a range 0.05 to 0.2 of an mg. Digitalization of a patient who has had no digitalis for the preceding two weeks may be accomplished rapidly by giving 0.6 gram of the whole leaf initially, followed by 0.2 gram every 6 hours until the patient is digitalized. With digitoxin the patient may be given 0.6 mg. initially, followed by 0.2 mg. every 6 hours until the patient is digitalized. The patient may be digitalized over a period of three days by giving 0.2 of a gram of digitalis leaf three times a day or by giving digitoxin 0.2 mg. three times a day.

The patient may be considered digitalized when satisfactory therapeutic effect has been achieved, when early toxic symptoms occur, or when his dose is in the upper range of the above digitalizing doses. If the patient has auricular fibrillation, in the absence of thyrotoxicosis or infection a satisfactory slowing of the ventricular rate to the neighborhood of 70 to 75 per minute may be used as a guide to digitalization. The common practice of employing 0.2 mg. of digitoxin daily as a routine maintenance dose is to be deplored since this dosage will produce digitalis poisoning in most patients.<sup>8</sup> In general, parenteral digitalis preparations may be used only if the patient has had no digitalis in the preceding two weeks. In an emergency 0.5 mg. of ouabain or 1.0 to 1.6 mg. of Cedilanid may be given intravenously, usually in two doses, each of  $\frac{1}{2}$  the total amount, each in four hour intervals. In general, unless congestive heart failure is precipitated by some acute event such as myocardial infarction, arrhythmia, or anemia, or is associated with a potentially curable etiology, digitalis, once begun should be continued for life. Digitalis should be used primarily to treat congestive failure and in the management of

certain auricular arrhythmias. It has no place as a prophylactic against congestive failure in persons with either normal or diseased hearts. In the presence of congestive heart failure, the only contraindication to digitalis is that of digitalis overdosage.

If one is to use digitalis properly, one must be familiar with the commoner manifestations of digitalis poisoning. Although anorexia, nausea, and vomiting are the most frequent early manifestations of digitalis poisoning they are seen in only  $\frac{3}{4}$  of the cases. Serious digitalis intoxication may develop in the absence of anorexia and vomiting. Headache, diarrhea, abdominal pain, red, green or yellow vision, scotomata, or a delirious hallucinatory state may be the first evidence of digitalis overdosage. On the other hand, the patient may be asymptomatic, but show numerous ventricular premature contractions, perhaps with bigeminal rhythm, interference dissociation, or even ventricular tachycardia as a lone manifestation of digitalis poisoning. One should suspect an arrhythmia appearing during the course of digitalization as a possible manifestation of overdosage.

### Sodium Restriction

Sodium restriction or depletion in the routine management of the failing heart is necessary only after satisfactory response to rest and digitalis is not observed. The degree of sodium restriction necessary will depend upon the therapeutic response of the patient. Sodium restriction may be accomplished by means of diet and by avoiding sodium-containing medications. If these measures are insufficient then sodium depletion may be resorted to through the use of diuretics.

The average diet without salt restriction contains six to 15 grams of sodium chloride per day. If salt is not added at the table the average diet contains 4 to 6 grams of sodium chloride per 24 hours. If the low sodium diet below is prescribed, it contains 1 to 2 grams NaCl per day. One quart of milk contains approximately 0.8 to 1.0 gram of sodium chloride. Rice and cereal may be added to this without appreciably increasing the sodium content. In the management of the patient with congestive heart failure who requires sodium restriction one may first try the effect



of using no salt in cooking or at the table. If this fails to produce the proper diuresis then it may become necessary to resort to the low sodium diet.

### Low Sodium Diet

In the space available it is impossible to describe this diet in full detail; however, some general statements may be made. With regard to meat, fish, poultry and eggs only one egg a day should be eaten. The meat or fish or poultry should be fresh or frozen only. One should avoid salted, smoked, canned, spiced, or pickled meats. Bacon and ham, shell fish, and processed fish should be eschewed. With regard to vegetables the following should be avoided: canned vegetables, endive, sauerkraut, kale, spinach, beets, and celery. Especially prepared salt-free bread should be used. Rice, barley, hominy, farina, and oatmeal are allowable. With regard to dairy products one should use sweet butter. Cottage cheese and homemade ice cream are permitted. One pint of milk a day is allowed. Hard cheese and commercial ice cream should be avoided. Allowable desserts are custard, pudding, and jello. Dried fruits, miscellaneous cakes, cookies, and candy should not be consumed. Miscellaneous prohibitions in the low sodium diet are olives, raisins, beer, mustard, ketchup, mayonnaise, pickles, relish, meat sauce, tums, baking soda, alka-seltzer, pretzels, salted peanuts, and popcorn.

### Proper Water Intake

Formerly the water intake in congestive heart failure was restricted to 800 to 1000 cc. of water per day. However, it is known that water is not retained unless sodium is retained also. With sodium restriction the patient may drink as much water as desired. He should in general drink as much as three liters per day. Excessively high fluid intakes of six to eight liters per day are recommended by some, but are cumbersome and are of unproved value in promoting diuresis.

### Diuretics

If the patient suffering from congestive heart failure fails to respond to the foregoing measures then one should consider the use

of diuretics to promote the excretion of water. In our clinic the diuretics which are used almost to the exclusion of all others are the parenteral mercurial diuretics. Oral diuretics are usually relatively ineffective or toxic. Oral mercurial diuretics have in our hands proved unsatisfactory because of the appearance of toxic symptoms in the dosage required to produce diuresis. Urea and xanthines have been relatively impotent. Ammonium chloride undoubtedly has diuretic action but is nauseating and, given over a few weeks constantly to the patient with renal impairment, may produce acidosis. Our use of ammonium chloride is restricted to occasional intermittent administration of dosage of  $1\frac{1}{2}$  grams four times a day for one or two days prior to the administration of a mercurial diuretic when the preceding response has been unsatisfactory. Our experience with the newer oral thiourea derivatives as diuretics has also not been too satisfactory. Cation exchange resins may be given to promote sodium loss through the bowel in doses of approximately 15 grams three times a day. A resin which has been saturated with potassium should be used so that potassium loss is not induced. These substances may combine with one to two milliequivalents of sodium per gram of resin. Our experience with these has not been too satisfactory. The patient who is ill enough to require additional diuresis often finds the preparation nauseating. Secondly, we have found that although the use of cation exchange resins may diminish the frequency with which parenteral mercurial diuretics may be given, we have not been able to replace mercurial diuretics entirely. Others<sup>9</sup> have had a more satisfactory experience.

The parenteral mercurial diuretics which we use at the present time are principally mercurhydrin and thiomerin. The mercurhydrin is given intramuscularly and the thiomerin subcutaneously. We do not give mercurial diuretics intravenously since there have been 32 fatalities reported following their administration by this route.<sup>10</sup> The number of fatalities recorded from intramuscular use is much smaller. We also prefer to begin the use of the diuretics with a smaller dose of  $\frac{1}{2}$  cc., gradually increasing if necessary up to 2 cc. A patient receiving mercurial diuretics should

be weighed daily. They should be given at such a rate that the patient loses not more than three pounds per day. The diuretics may be given on alternating days until the desired effect is achieved. The interval between them should then be increased until they can be discontinued entirely or until the proper interval is discovered. It is thought undesirable to reduce the patient to his dry weight as has been advocated by some.

Contraindications to the mercurial diuretics are not numerous but they include renal disease associated with blood urea nitrogen retention over 60 mg. per 100 cc.<sup>11</sup> Failure of the patient to respond by diuresis after a few injections or the appearance of potentially dangerous side effects, such as severe dyspnea or substernal discomfort, rash, urticaria, chills, fever, pallor, cyanosis, palpitation, tachycardia, fall in blood pressure, collapse or convulsion, may herald a fatality if the same diuretic is employed again. Parenteral mercurial diuretics have several side effects of which one should be aware. This includes first of all local reactions, such as pain or swelling, which may usually be avoided if the diuretic is given intramuscularly rather than subcutaneously. Signs of mercurialism, such as stomatitis, nephrosis or skin rash, may occur. A systemic reaction characterized by collapse, substernal pain, arrhythmia, asthmatic breathing, nausea, vomiting, chills, fever, or even sudden death, may ensue. One should also be on guard for the salt depletion syndrome which may occur as a side effect of the use of these substances. Muscular cramps, stupor, headache, anorexia, thirst, and poor turgor of the tissues may result. Examination of the serum electrolytes may show a low serum sodium. This syndrome is more likely to occur if there is renal insufficiency. It may be treated by giving 250 cc. of 3 to 5 percent sodium chloride cautiously intravenously.

There are several types of congestive heart failure in which digitalis is often relatively ineffective. In these the parenteral mercurial diuretics may be of great value. These types of congestive failure are (1) active rheumatic myocarditis, (2) mitral stenosis with pulmonary edema alone, (3) heart failure due to coronary artery disease or hypertension with left ventricular failure only, (4) many types

of congestive heart failure with normal sinus rhythm, (5) cases which have responded to digitalis but are no longer controlled by digitalis.

A daily chart of the patient's weight will be of great help in evaluating his response to treatment and in proper spacing of the diuretic injection.

### Additional Therapy

In addition to the above six factors which have been outlined for the routine management of the failing heart there are certain miscellaneous items which may be of importance. If the patient is obese, reduction of the weight to normal or slightly below normal level may relieve the work of the heart. Cough should be controlled since it may tend to precipitate pulmonary edema. Often the cough is best controlled by relieving the congestive failure. It may prove desirable to insure rest at night by small doses of a sedative. If the patient must be at absolute bed rest the routine use of anticoagulants may be considered. A recent study showed a reduction of the fatality rate in patients with congestive heart failure from 18 percent to 7 percent if anticoagulants were used.<sup>12</sup> Oxygen by tent, mask or nasal catheter need not be given routinely. It may be indicated if the patient has cyanosis, pulmonary edema, pulmonary infarcts, emphysema, pneumonia, atelectasis, fibrosis of the lung, or myocardial infarction. Mechanical fluid removal is not often needed since the use of the mercurial diuretics has become more common. Paracentesis of the abdomen need rarely be done in congestive failure. Occasionally one may need to remove fluid from the chest to relieve dyspnea and much less often a Southey tube or large gauge needle may be needed to drain fluid from the legs. Finally, in patients with congestive heart failure which has proved refractory to all measures, one may consider the patient a candidate for the induction of hypothyroidism by the use of radioactive iodine.<sup>13</sup> One in general tries to reduce the patient's basal metabolism rate to -25 to -15 percent, thus reducing the demand upon the heart. Some patients achieve rather dramatic relief as the result of this treatment.

A few words about the treatment of acute left ventricular failure leading to pulmonary



edema are in order. Morphine is of great value in treating this condition. Tourniquets may be used on either three or four extremities. It is preferred to use them on three extremities and to rotate them every 15 minutes. If the use of tourniquets does not achieve the desired effect then a rapid phlebotomy of 300 to 500 cc. of blood may have a salutary effect. This form of therapy is not usually effective unless the venous pressure is elevated. The patient should be digitalized rapidly by ouabain or Cedilanid, as outlined previously, if he has had no digitalis in the preceding two weeks. If the patient is not in shock the use of 100 percent oxygen with positive pressure of 2 to 4 cm. of water for a short period may be of great value. Aminophylline,  $\frac{1}{4}$  of a gram, given slowly intravenously is also of therapeutic benefit. The mercurial diuretics should be given; although they will not usually be of benefit for the acute attacks, they will tend to prevent a recurrence.

In conclusion, we would like to consider what should be done for the patient who has congestive heart failure and who does not respond to any of the measures described above. One of the commonest causes of failure to respond is the improper use of the therapeutic regimen. One should check each item point by point to be sure that it is being properly employed. One should examine the patient carefully to look for an occult infection which may be responsible for his continued failure. Pneumonia, pyelonephritis, bacterial endocarditis, and myocarditis are not uncommon concomitants of congestive failure. As has been mentioned previously, anemia, thyrotoxicosis, beriberi and constrictive pericarditis may all be causes of failure to respond to digitalis and the other outlined therapy. Digitalis poisoning with production of arrhythmia may be responsible for refractory heart failure. Renal insufficiency, pulmonary embolism, sodium depletion, hypo-

chloremia and an obstruction in the lower urinary tract may be responsible for the failure to respond to the routine treatment or management of the failing heart. Correction of these difficulties may be necessary before the usual response to the conventional treatment can be anticipated.

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# "ADULT" TESTICULAR TERATOMA IN A CHILD

## A Case Report

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TESTICULAR TUMORS in children are rare, but when they do occur they are usually teratomas and are usually of the malignant type.<sup>1, 2</sup> Willis, in analyzing 1,066 postmortem tumors of all kinds, found only one teratoma in the first two decades of life and Anderson reported no testicular teratomas in her series of 768 childhood tumors.<sup>3, 4</sup> Merren, reporting on a series of cases from the University of Virginia Hospital from 1921 to 1949, found 67 teratomas, the youngest patient being 18 years of age.<sup>5</sup> Gilbert, quoted in Matassarian's paper, reported 131 testicular tumors in patients under 15 years of age out of 5,500 cases collected between 1803 and 1942.<sup>6</sup> Eighty-nine of these were teratomas. The youngest age recorded by Gray was 17 months but Boehme noted the presence of a teratoma in a four month old infant.<sup>2, 7</sup>

### Case Report

This two year old patient (J. S.) was noted to have an enlarged right testis at birth or shortly thereafter. It seemed to enlarge slowly over the years but was never painful and remained asymptomatic. No weight loss had been recorded. Several physicians were consulted but they advised continued observation.

At time of examination the right testis and epididymis seemed to be involved in a firm, somewhat nodular mass about three times normal size. The mass did not involve the scrotum itself, however, and the inguinal rings were intact. The swelling did not transilluminate. It was felt that this was probably a tumor, but the possibility of a thick-walled hydrocele or hematocele had to be considered. There was no local or distal palpable lymphadenopathy and no palpable liver or spleen. The chest x-ray appeared normal.

The patient had a right orchiectomy under

ether anesthesia. The spermatic cord was ligated at the internal inguinal ring and the cord and testicle were removed, in one piece. The post-operative course was quiet except for an episode of tonsillitis, and he was discharged ten days postoperatively.

Ten weeks after operation a follow-up examination revealed a healed scar with no apparent changes in the opposite testis and still no palpable masses, nodes, or viscera. The child was eating well and asymptomatic.

Laboratory: There were 9,200 WBC/cmm. with 47 percent neutrophils and 45 percent lymphocytes, with 4.1 million RBC/cmm., and 13 grams of hemoglobin per 100 cc. The urine was free of albumin and sugar, and was normal microscopically.

Grossly the testicle measured 4.3 cm., with a 7.5 cm. long spermatic cord. Upon cutting the mass, greasy gray material and hairs were noted. The tumor was multicystic, and contained spaces up to 3.8 cm. in diameter. Areas of bone formation were present.

Microscopic examination revealed sections of infantile testicle compressed by a tumor consisting of organoid structures derived from all three germ layers. These structures included central nervous system tissue with ependymal cells, bronchial tissue, and intestinal tissue.

The tumor appeared histologically benign in spite of a few clusters of glandular epithelial cells which appeared embryonic. (J. Cain, Pathologist.) The impression was "adult" teratoma, and this diagnosis was confirmed at the Third Army Laboratory, Fort McPherson, Georgia.

A urine specimen collected four weeks after surgery and sent to Walter Reed Hospital revealed no measurable mouse units of prolactin.

### Discussion

Testicular tumors may be classified as seminomas, embryonal carcinoma and chorioepitheli-

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oma, teratoma and teratocarcinoma.<sup>8</sup> The teratoma totalled about 7 percent among 922 testicular tumors reported by Friedman.

The term "adult" teratoma is used when no histologically recognizable malignant components are present, while teratocarcinoma refers to mixtures of teratoma, embryonal carcinoma and/or chorioepithelioma.<sup>8</sup> The term benign is better not used since "adult" tumors appearing as teratomas have metastasized, according to Friedman. The most likely explanation of this is that a malignant teratocarcinoma matured into an adult teratoma after the malignant embryonal cells had already metastasized. Some of these tumors, therefore, apparently remain malignant, while others become benign either before or after metastasizing.<sup>9</sup> The majority of the malignant ones declare themselves in the first few years of life.<sup>3</sup> They metastasize widely to the iliac and lower lumbar nodes, along the spermatic veins to the celiac nodes, and by vascular channels to the liver, brain, lungs, and bones.

Pathologically, the adult teratoma is moderately sized and composed of firm gray-white tissue with cystic spaces, foci of epithelium and cartilage. It is usually sharply circumscribed from the compressed testicular tissue.<sup>9, 10</sup> The cystic spaces often contain hair, sebaceous material and are lined by epidermis.<sup>11</sup>

Microscopically, there is great variability of cellular and tissue elements, but all the elements are organized. Each cellular type can occur singly or in combination with any of the other cell types.<sup>9</sup> Most of the elements resemble normal tissue and may reveal extensive organ rudiments such as cerebral tissue, and liver.<sup>10, 11</sup>

According to Andersen these tumors may arise as embryonal rests and are actually congenital, since the cells and tissues suggest those of the embryo.<sup>3</sup> Moore feels that the same factors which are responsible for organization of the normal embryo are operative, in part, in the teratoma.<sup>9</sup>

The earliest symptoms are unilateral testicular enlargement, usually of the right, and later, with metastases abdominal enlargement. Boehme felt the tumors were often associated with cryptorchism. Pain occurs late, as does suppuration and sloughing.<sup>1, 2, 7</sup> Depending on the extent of the metastases there may be weakness, appetite loss, nausea, and vomiting, epigastric distress, backache and cough. A history of acute painful

swelling with redness and fever is lacking, and gynecomastia or pigmentation about the areola are only rarely noted.<sup>7, 12</sup>

The clinical course is usually slow, and many are present at birth and slowly enlarge, although some may grow very rapidly.<sup>2, 11</sup>

In making the all-important early diagnosis it is necessary not to dismiss all painless scrotal swellings occurring in infants as simple hydroceles as was done in the case reported. Hematocele, syphilis, hernia, orchitis, tuberculosis, cyst, and benign tumor must be considered. Careful transillumination is indicated, as often a small hydrocele is present.<sup>2</sup> Besides the history, bimanual palpation is by far the most important diagnostic aid, although the urinary hormone levels may be helpful in diagnosis and prognosis.

In 1920 a definite relation between increased amounts of urinary gonadotropin and the presence of a testicular tumor was established, the tests, according to Boehme, being diagnostic in 85 percent of the cases.<sup>2, 9</sup> Ferguson in 1932 showed that prolan appears in the urine in all varieties of testicular teratoid tumors, increasing in amount with the increase in the embryonal character of the tumor. Moore has suggested that a cell type structurally resembling early developmental stages of mammalian placenta is responsible for these positive tests. Extirpation or effective irradiation causes a sharp reduction or disappearance of prolan in about two weeks. Less than 500 mouse units is compatible with disease, but seminomas yield 500 to 1,000 units, embryonal carcinomas 2,000 to 10,000 and choriomas above 10,000 units.<sup>7, 9, 12, 13</sup>

Moore, however, felt the urinary gonadotropin studies are not significant in the teratomatous tumor, and a negative test is of no significance either diagnostically or prognostically.<sup>9, 10</sup>

The prognosis of testicular tumors is poor. Moore, in a follow-up of two to ten years, found 50 percent of the patients dead, 95 percent of the fatalities occurring within the first two years. Eighty of Gray's 127 cases died within the first year. It would seem, then, that all testicular tumors, even those such as a teratoma which appears histologically benign, are malignant or potentially so, since the adult-type teratoma is derived from the malignant teratocarcinoma.<sup>8</sup> Out of the 127 cases of testicular teratoma reported by Gray, 65 had metastases on the first visit.

Each cell type of testicular tumor, however, has a different prognosis. The urinary gonadotropin may be helpful in prognosis. A failure in reduction after surgery is unfavorable, as is the return of prolan after two weeks<sup>10, 13</sup> Ferguson reports, however, that about eight months after a successful operation prolan may recur in the absence of disease, for undetermined reasons.

Treatment consists of orchiectomy with or without irradiation, since the adult teratoma is highly radioresistant. Treatment should not depend on the urinary hormone levels. Most investigators report best results with simple orchiectomy followed by irradiation.<sup>2, 11</sup> Moore, however, felt that since many growths involved the spermatic cord and surrounding tissues, as well as the local nodes, they should be removed in a radical type operation. Dean reports that among 72 percent with inoperable metastases there were 29 percent five-year cures using post-operative irradiation. Memorial Hospital in New York, however, favors preoperative irradiation followed by orchiectomy.<sup>14</sup> Lewis, in a study of 250 cases, felt that radical orchiectomy without irradiation was indicated for teratomas, while irradiation was valuable only when inoperable metastases were present.

In infants, of course, the benefits of irradiation must be weighed because of the danger of damage to the other testis and the nearness of the epiphyses of the pelvis and upper femur.

In the patient reported in this paper irradiation was not given because of the history of the tumor being present for two years without obvious metastases, the microscopic picture of an adult teratoma, the danger of epiphyseal involvement, and a negative prolan test four weeks after surgery.

### Summary

1. "Adult" teratomas of the testis in children are unusual.
2. A case of "adult" teratoma in a two year old child is reported.

3. A painless persistent swelling in the scrotum in children should be considered a malignancy until proven otherwise, and not merely a simple hydrocele.
4. The danger of malignancy is obscure and testicular enlargements make exploration or orchiectomy mandatory.

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# CARCINOMA OF THE BREAST

## Pathologic Changes Correlated With Diagnosis, Treatment and Prognosis

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THE clinical appraisal of a single lump in the breast is notoriously inaccurate. Medical students will make a 45 percent error (5 percent worse than tossing a coin). Experienced examiners can diagnose a single lump of the breast correctly in only 70 percent of instances. Therefore, it is obvious that the attitude of *look and see* should be substituted for the attitude of *wait and see*. Palpation of the axilla to determine the presence or absence of lymph node involvement in carcinoma of the breast is extremely inaccurate even for competent examiners. Small lymph nodes have practically the same consistency as the breast tissue and cannot be felt. In a series of cases studied at the Ellis Fischel State Cancer Hospital the following findings were obtained. If the examiner believed that the axilla was involved, he was correct in 85 percent of instances. He was wrong usually in cases with ulceration and infection. Such changes would also cause enlargement of the regional lymph nodes. If the examiner thought that the lymph nodes were not involved, he was wrong in 46 percent. (Table 1).

TABLE 1  
Clinical Impression vs. Microscopic Findings

Clinically neg. and microscopically neg.	84 cases	Examiner correct in 54 percent of cases
Clinically neg. and microscopically pos.	71 cases	
Clinically pos. and microscopically pos.	124 cases	Examiner correct in 85 percent of cases
Clinically pos. and microscopically neg.	22 cases	

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The overall error in this group of cases was 31 percent. These statistics should be kept in mind for they emphasize the high percentage of error in appraising the clinical extent of disease in patients with carcinoma of the breast.

### Indications for Frozen Sections

In any lesion which is at all debatable, a frozen section should be done. The pathologist should preferably have examined the breast of the patient before operation, and be appraised of all pertinent clinical data. In most instances the gross examination determines whether a lesion is benign or malignant. The hardness of the lesion is not necessarily an attribute of a malignant neoplasm, for this phenomenon indicates only the amount of connective tissue present. In fact, a fibroadenoma at times may become calcified and be as hard as a rock. The most important gross finding is the appearance of small granular chalky streaks within the tissue. At times, with compression of the biopsy specimen or the excised nodule, small worm-like masses of tumor will be extruded from thickened ducts.

In frozen section diagnosis, a definitive opinion should be possible in 95 percent plus of the instances. Our policy is to give three possible answers, either that it is a benign process, a malignant neoplasm or that we cannot make a definitive diagnosis. In cases in which there is a papillary process, we do not make a definitive diagnosis because of the great difficulties, even with paraffin sections, of differentiating between a benign and malignant tumor. If we cannot make a definite

diagnosis, the surgeon is told and he closes the wound and awaits the paraffin section. We have no evidence that such a procedure is of any harm, and in certain doubtful cases an attempt to make a positive diagnosis might result in ablation of the breast for a benign lesion. *Fat necrosis* is often mistaken clinically and grossly for carcinoma (Adair). It may be attached to the skin, may be hard, and there may be edema of the skin overlying it. On section it has a slightly greasy appearance and has a brown, rather even color. Microscopically there is invariably duct stasis and differentiation is usually easy. In *sclerosing adenomatosis* the tissue may be quite firm; the process, however, is usually diffuse within the breast and may dilate or fill thick-walled ducts. It cuts smoothly and does not present the usual chalky streaks. With poor frozen sections the distortion produced by the fibrous tissue and the papillary formation may give an erroneous impression of carcinoma (Urban). *Plasma cell mastitis*, a rare entity in our experience, also may be associated with edema and a firm mass. The great cellularity of this lesion may also result in an erroneous diagnosis on frozen section (Cutler). It is true that this lesion, like fat necrosis, may be secondary to a carcinoma. Haagenson suggests that when a frozen section is contemplated an incisional biopsy of a breast mass be done so that the tumor bed will be disturbed as little as possible. We are in sympathy with this concept and follow it whenever the lesion is large and apparently homogenous throughout. However, as we have noted in numerous instances, if the lesion is small, incisional biopsy may miss the carcinoma. It is our policy, therefore, to remove small lesions in toto. They are then sectioned and the most suspicious areas selected for frozen section. Recently when a small mass measuring approximately 2.5 cm. was excised, a carcinoma measuring less than 1 cm. was found in this mass. If incisional biopsy had been used, the tumor might have been missed.

### Aspiration Biopsy and Exfoliative Cytology

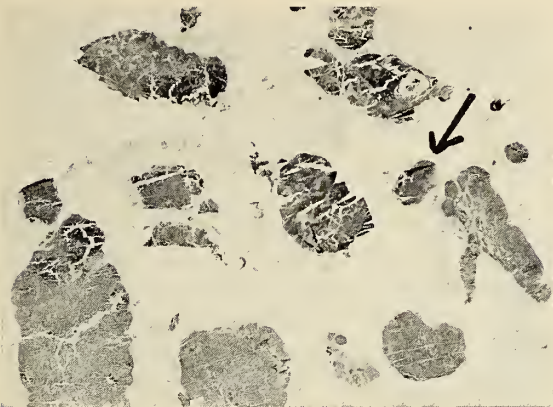
Aspiration biopsy is sometimes recommended as a method of diagnosis of carcinoma of the breast. We feel that this method is

not indicated except in patients with advanced disease where a diagnosis is to be made merely for the record in order to proceed with irradiation therapy. Aspiration biopsy in operable cases is not indicated for it may completely miss the neoplasm and certain proliferative lesions may be extremely difficult to interpret. Incisional biopsy and frozen section is much more certain. Exfoliative cytology has been used for the study of secretions from the nipple (Saphir). However, if a patient has a mass in the breast near the nipple, it is much easier to excise this lesion. We do not feel that it is practical to use exfoliative cytology as a method of diagnosis. It is difficult, time consuming, and rarely gives information which could not be more easily obtained by more conventional methods.

It is our recommendation that operations on any patient with a small nodule in the breast should be done in an operating room with facilities for a frozen section, and preferably that the surgeon who operates should be qualified to do a radical mastectomy if the local process demonstrates carcinoma. In some instances, however, local excision of a nodule thought to be benign has been done in a doctor's office or a clinic, and a diagnosis of carcinoma has been returned by the pathologist. In such cases, if the tumor is small, has been cleanly removed and nothing further has been done, we have been unable to demonstrate that harm results if radical mastectomy is resorted to within a relatively short time, preferably no longer than two weeks. By contrast, we cannot condemn too strongly the practice of doing simple mastectomy for supposedly benign lesions. If the lesion turns out to be carcinoma, the long-time results in such cases are almost uniformly poor. Apparently the surgeon undermines a wide area, implants carcinoma on the fascia and spreads tumor over the entire operative field. In time this results in local recurrence and/or regional lymph node metastases. If radical mastectomy is resorted to fairly soon after clinical persistence is apparent, with few exceptions these patients die. Of 30 patients with previous carcinoma who had a simple mastectomy, it was possible to do a radical mastectomy in 17 cases; the other 13 had advanced disease. At the time of follow-up,



Figure 1A



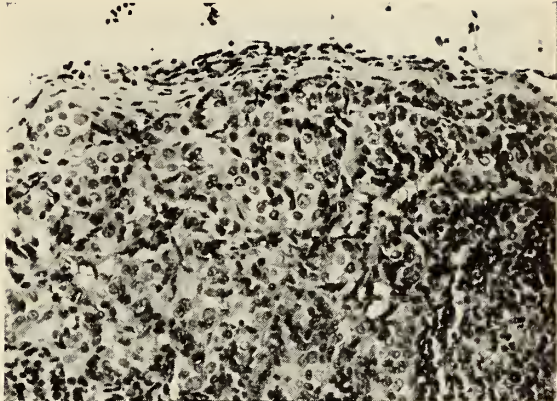
Photomicrograph (low power) of a group of lymph nodes found in an axillary lymph node dissection. The arrows point to a 2 mm. lymph node which was partially replaced by tumor, the only lymph node involved in this dissection. WU 52-1223.

only 2 of the 17 were living without disease (Lockhart and Ackerman).

Pathologic Examination of Radical Mastectomy Specimens

The most complete way to examine the axilla would be to clear the axilla and section each node serially. Such a study is obviously too time-consuming, financially impossible from the technical standpoint, and of doubtful practicality. We feel that the information gained would be very similar to the findings we obtain by our rather thorough examination, a procedure well within the possibilities of any pathology laboratory. In this group of 316 radical mastectomies in which the axillary contents were available for study we found a total of 6,041 lymph nodes. The highest number of nodes found in one patient was 79, and it was rare to find less than 15 after we learned how to examine the axilla. The size of the nodes varied between 0.2 cm. and several centimeters. It was not rare for a palpable large lymph node to be free of tumor while a small node in the immediate vicinity contained metastatic carcinoma. The photomicrograph depicts the size of nodes which can be found in a meticulous dissection. One of the nodes shown is invaded; it measured 0.2 cm. (Figs. 1A & 1B.) We have introduced this method of study at Washington University. We feel that the resident staff in pathology or residents rotating through from the

Figure 1B



Photomicrograph of the node shown in Figure 1A. Tumor is partially replacing a lymph node. 52-1228.

surgical services can be trained to examine adequately the axillary content. The average number of nodes found at Barnes Hospital by them has been 24.3 (Table 2).

TABLE 2  
Average Number of Nodes Per Specimen  
Barnes Hospital, St. Louis, Missouri

Date	Average No. Nodes	Total No. Specimens	Average No. Per Specimen
July 1948-Dec. 1948	668	28	23.8
Jan. 1949-Dec. 1949	1,771	72	24.6
Jan. 1950-Dec. 1950	1,764	79	23.6
Jan. 1951-Dec. 1951	2,116	82	25.8
Total	6,319	261	Average 24.3

At Barnes Hospital the patients had earlier carcinomas than the cases seen at the Ellis Fischel State Cancer Hospital. At both hospitals the technique of radical mastectomy was similar. As has been stated by Monroe, the more radical the mastectomy the larger the number of lymph nodes found. We feel that this careful dissection of axillary contents will demonstrate with a high percentage of accuracy whether the axillary lymph nodes are or are not involved by tumor. Saphir recommended serially sectioning axillary lymph nodes. Otherwise, he stated that the examination is inaccurate. He had 30 cases in which the axillary lymph nodes were apparently negative. By serially sectioning this group he found involvement in 10 of the 30 cases. It should be pointed out that the average number of nodes found in these 30 cases was slightly under five. We believe that

a careful dissection of the axillary with the average number of 25 lymph nodes is accurate in almost 100 percent of instances in determining whether the axillary lymph nodes are involved or not involved.

We can prove this indirectly by a review of the patients who died who had no evidence of axillary metastases. These data are available on the patients seen at the Ellis Fischel State Cancer Hospital. These 312 patients have been followed from five to twelve years with no patients lost to follow-up. These patients were treated primarily by surgery and practically none of them had either pre- or postoperative irradiation therapy. In the years 1944 through 1947 there were 58 patients who had no evidence of regional lymph node metastases. Twenty of these patients are now dead. Four of these died of intercurrent disease without evidence of cancer. Four developed other types of cancer from which they died. In six cases we had no explanation of the cause of death. Only three of these patients, however, had clinical evidence of recurrent cancer. Six patients had carcinomas in the inner quadrant.

We feel that this location may indicate that the tumor has spread to the anterior mediastinal lymph nodes. A recent case illustrates this point. A patient had a 2.5 cm. tumor located in the upper inner quadrant. The second intercostal space was explored and the material obtained did not appear to be diagnostic. Radical mastectomy was done. Thirty-four axillary lymph nodes were negative, but a 4 mm. lymph node in the anterior mediastinum showed partial replacement by tumor. In the absence of axillary lymph node metastases spread to the supraclavicular lymph nodes is unlikely. Andreassen and Dahl-Iversen investigated the supraclavicular space in 98 patients with operable breast cancer. In forty-seven cases in which the axillary lymph nodes were not involved there were no instances of involvement of supraclavicular lymph nodes. In the fifty-one cases with axillary node involvement seventeen, or one-third, also had involvement of the supraclavicular lymph node.

In patients seen at the Ellis Fischel State Cancer Hospital there were 48 cases in which the primary tumor arose from the inner quadrant. Eighteen had no axillary lymph node involve-

ment and only seven (39 percent) are living. This percentage is 20 percent less than the overall survival of all cases without lymph node involvement. Thirty cases had lymph node metastases and only eight are living (27 percent). These findings are well substantiated by Handley who found that the internal mammary lymphatic chain is often invaded at the same time as the axilla and sometimes before it, especially if the growth is in the medial half of the breast. Fourteen had already metastasized to the internal mammary chain. In five the internal mammary nodes alone were involved without involvement of the axillary nodes.

Probably a much higher percentage of lymph nodes in the internal mammary chain are involved than Handley's figures indicate. This supposition is supported by the follow-up of our patients with inner quadrant lesions. In view of the extremely poor prognosis in such patients, some change in therapy could be contemplated. Any attempt at radical surgical removal of the internal mammary chain must meet with failure, because it is obviously impossible to do an acceptable cancer operation. The surgeon removes some but not all of the lymph nodes (Urban). If he does the operation Urban recommends he will leave involved lymph nodes in the first interspace. The only operation that has a chance of radically removing the lymph nodes has been done on a series of patients by Wangenstein. He sweeps the anterior mediastinum and does a thorough dissection. However, in a recent review of his cases he had three deaths from possible air embolism.

There are also two groups of cases in which the operation would not benefit the patient. This included the cases in which all the lymph nodes were negative and the cases in which all of the lymph nodes were positive. In the first group the operation was not indicated and in the second group he obviously left residual cancer. Finally, this operation is not without considerable morbidity. There is an argument for routine irradiation of the anterior mediastinal and supraclavicular areas for carcinomas arising in the inner quadrant. Should the second and third intercostal space be explored for lesions located in the inner quadrant? If frozen section shows the nodes to be involved, should the operator



terminate the procedure and irradiate the breast and anterior mediastinum? The argument against removing the breast would be spreading the cancer over a wide field on the chest wall, making irradiation more difficult. The argument for removing the breast would be to remove the axillary lymph nodes. Secondly, local recurrence of operable breast cancer, either on the chest wall or in the axillary area, only infrequently occurs. In the patients with axillary node involvement, as Andreassen has shown, at least one-third have supraclavicular lymph node involvement. This figure is undoubtedly much lower than actual facts, for the cure rate of carcinoma of the breast with axillary lymph node metastases is never any higher than 40 to 50 percent.

With these facts in mind a new routine for the treatment of carcinoma of the breast could be entertained. No pre-operative irradiation is to be given.

For operable carcinomas arising in the central and inner quadrants:

- A. Explore the second and third intercostal spaces. Such exploration is merely for the record of whether nodes obtained are positive or negative for cancer.
- B. Complete the radical mastectomy.
- C. If the axillary lymph nodes are negative, irradiate the anterior mediastinal and supraclavicular areas.
- D. If the axillary nodes are involved, irradiate the anterior mediastinal and supraclavicular areas.

For operable carcinomas arising in the outer quadrants:

- A. Explore the second and third intercostal space.
- B. Do the radical mastectomy.
- C. If the axillary lymph nodes are involved, irradiate the supraclavicular and anterior mediastinal area. If the axillary lymph nodes are negative, do not irradiate.

This plan of treatment might improve the results of the treatment of carcinoma of the breast. In order to prove it, a large series of cases with thorough pathologic study

would have to be collected. Follow-up over a ten year period would be necessary. Cases should be alternated. This plan of treatment, particularly from the standpoint of irradiation, is predicated on treating the cancer where it is and not treating large areas of chest wall where the chance of cancer being present is small.

The single most important factor in the prognosis is the presence or absence of involved axillary lymph nodes. In the 312 cases seen at the Ellis Fischel State Cancer Hospital 205 patients had involved axillary lymph nodes and only 54 of these are living. One hundred seven patients had negative lymph nodes and 64 of these are living. The number of lymph nodes involved is also of importance. The greater the number involved, the worse the prognosis. There were 30 patients who had only one lymph node involved and 9 of these are living. There were 56 who had over ten lymph nodes involved and only 8 are living. The location of the involved lymph nodes has relative importance. At the Cancer Hospital in the patients with involvement of the high point and other nodes there were 42 patients, of whom only 8 are living. It is rare to have high point alone involved. There were only five cases and three out of the five are dead. If the low axilla alone is involved you would believe the prognosis would be fairly good. There were 23 patients in this category and, unfortunately, 15 of these are dead.

There are other facts which should be included with the lymph node involvement in consideration of prognosis. There were 17 cases with nerve sheath invasion. Only 2 had negative lymph nodes and only 4 patients are living. One of these four had negative lymph nodes. There were 26 patients who had involvement of the underlying muscles. Nineteen of these had lymph node involvement and 18 of the 19 are dead. Seven with muscle invasion did not have lymph node involvement and 4 of the 7 are dead. Vein invasion has an extremely ominous prognosis. Twenty patients had vein invasion. All had lymph node involvement and 18 out of the 20 are dead.

There is direct correlation between the size of the tumor and axillary lymph node involve-

ment. The larger the tumor the higher the percentage of axillary lymph nodes involved (Table 3).

TABLE 3

Relative Size of the Tumors With and Without Positive Nodes  
July 1948 to Jan. 1952, Barnes Hospital, St. Louis, Missouri

Size	No. of Cases Without Involved Lymph Nodes	No. of Cases With Involved Lymph Nodes	Percentage Involved
2 cm. or below	40	21	34.4
2 to 3 cm.	31	30	49.1
3 to 4 cm.	16	23	58.9
4 to 6 cm.	14	24	63.1
Over 6 cm.	3	18	85.7
Diffuse	11	15	57.6
Not mentioned	11	12	52.1
Total	126	143	53.1

It must be emphasized again that small nodes may be involved by tumor. For instance, there were 25 cases in which only one lymph node was involved. The total number of lymph nodes examined averaged 25 in these cases. The average size of the single lymph nodes involved measured 6.7 mm. and there were 7 cases with lymph nodes 5 mm. or less in size. The smallest single node involved measured 2 mm. There is supposedly also a correlation between the differentiation of the tumor and the incidence of metastases. At Barnes Hospital we had 61 cases of tumors measuring 2 cm. or less. We feel that consciously or unconsciously, if a pathologist knew whether the axillary lymph nodes are involved, or whether the patient is living or dead, that this knowledge might influence the grading of a given neoplasm. These 61 tumors were graded without knowledge of whether the axillary lymph nodes were involved or not. The results obtained are as shown in Table 4. These results were reproducible with minor exceptions. In 75 percent of instances the grade was the same, but in 25 percent the grade was either one higher or one lower. These results indicate very poor correlation between grading and metastases. It has also been shown that if several sections are taken of the primary tumor that different growth patterns may be observed. (Figs. 2A, B, C, D). If grade one is restricted to the few carcinomas in which the growth is entirely intraductal, then practically none of these will metastasize and the prognosis will correlate very well with the grade. There will also be a few highly undifferentiated neoplasms

which will do poorly. However, the majority of the tumors show a variegated pattern and fall in a large group in which grading has limited value.

TABLE 4

61 Cases of Carcinoma of Breast Measuring 2 cm. or Less

	With Metastases	Without Metastases	Total
Grade 1 & 2, Combined	4 (26%)	13	17
Grade 3 & 4, Combined	17 (38%)	27	44
Grade 1	3	6	9
Grade 2	1	7	8
Grade 3	10	20	30
Grade 4	7	7	14

We have found that there are exceptions to every rule we have made. There is a small percentage of cases in which the pathologic findings show a large, poorly differentiated tumor with involvement of lymph nodes and yet the patient persists in living despite the dire predictions of the pathologist. The case illustrated demonstrates an undifferentiated carcinoma in a patient who had 10 out of 10 lymph nodes involved but who was living 11 years after radical mastectomy. (Fig. 3.)

Classification of Breast Carcinoma

The classification of breast carcinoma is of value only if it is useful for prognosis or treatment. Any classification must of necessity be somewhat artificial, because carcinoma of the breast, an epithelial neoplasm, must arise from either the duct epithelium or the acinar epithelium. Modifications of gross pattern can result when there is an excess production of connective tissue by the tumor or a variation of growth pattern within or outside of the ducts (Muir). It is unfortunate that a very high percentage of all breast carcinomas fall into a broad intermediate group. The following classification indicates the relative frequency of the various types:

Type	Relative Incidence
Arising from duct epithelium	
Carcinoma (no specific type)	Over 75 percent
Carcinoma plus Paget's disease	About 2 percent
Comedo carcinoma	About 4 percent
Medullary carcinoma	About 5 percent
Acute carcinoma (Inflammatory)	Less than 5 percent
Papillary cystadenocarcinoma	Less than 5 percent
Mucinous carcinoma	About 2 percent
Epidermoid carcinoma	Less than 1 percent
Arising from acinar epithelium	
Lobular carcinoma	Approximately 5 percent



Fig. 2A

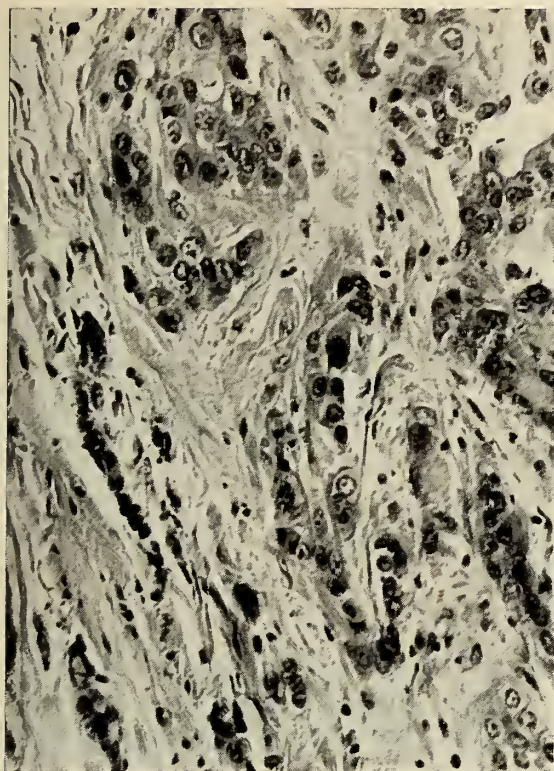


Fig. 2B

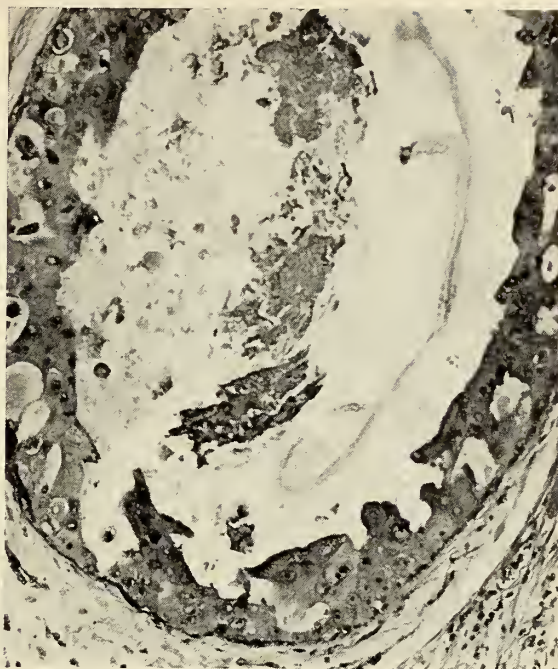


Fig. 2C

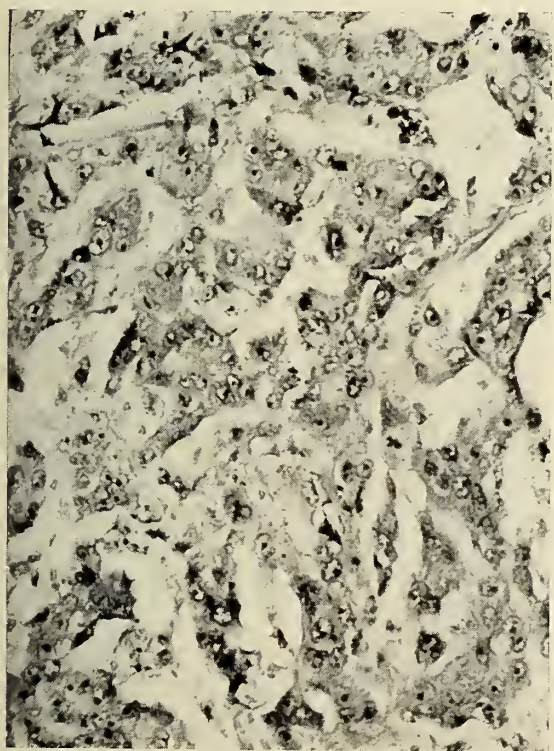
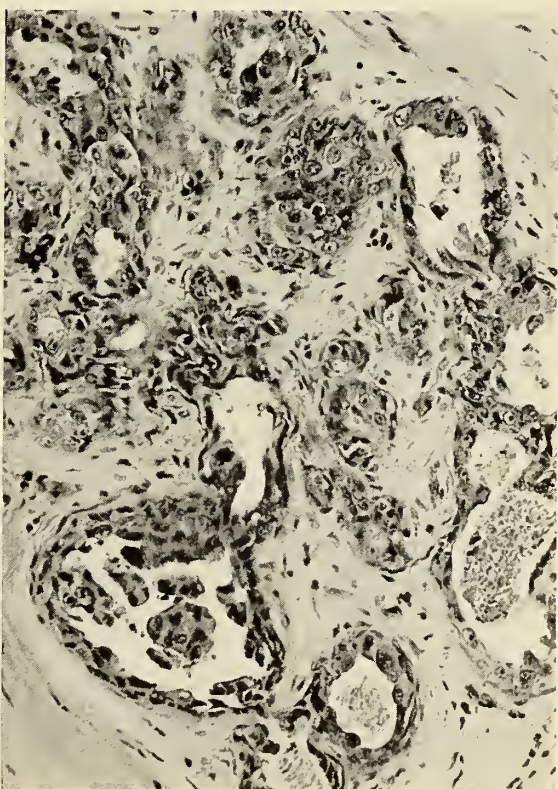


Fig. 2D

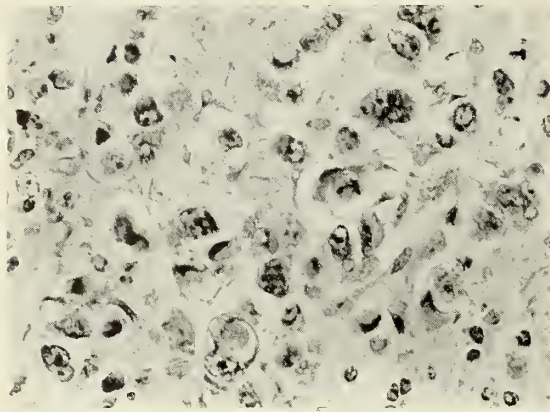


Figures 2A, B, C, D

Variable patterns in the small carcinoma of the breast. This illustrates one of the difficulties of grading carcinoma of the breast. WU 52-1235, 52-1232, 52-1231, 52-1233.

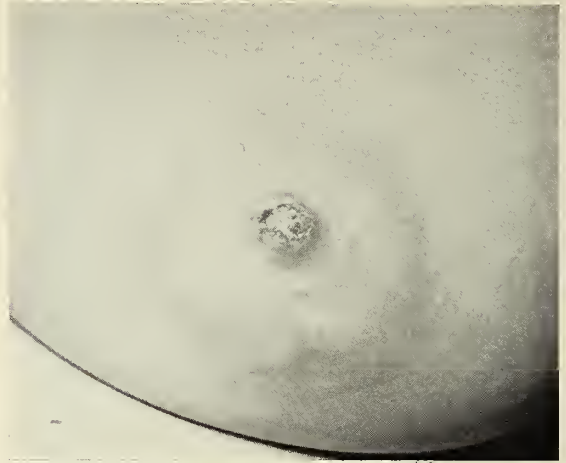


Figure 3



Photomicrograph of an undifferentiated carcinoma of the breast. This patient had a radical mastectomy in 1941 and had ten out of ten lymph nodes involved. The patient is living in 1952 without evidence of disease. WU 52-1230.

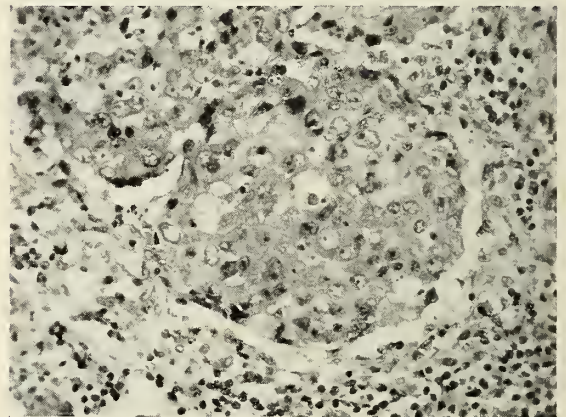
Figure 4



Early Paget's Disease. Note restriction of the process to the nipple. WU 46-1456.

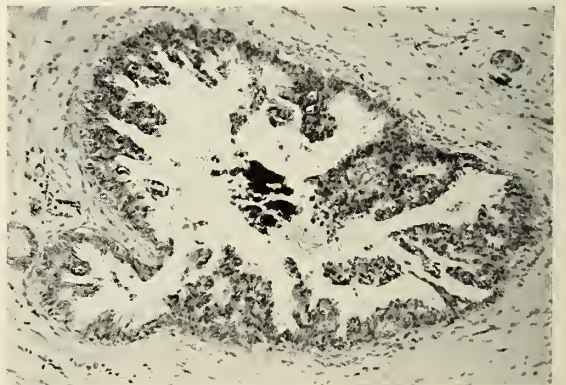
Paget's disease represents involvement of the nipple secondary to underlying carcinoma. (Fig. 4.) This should never be treated locally; radical mastectomy is the treatment of choice. Comedo carcinoma tends to grow mainly within the ducts due to a defense mechanism set up by thickened duct walls, and for that reason metastasizes a little more slowly. Medullary carcinoma, recently described in detail by Moore and Foote, has a good prognosis and a distinctive gross and microscopic pattern (Fig. 5). The inflammatory type of carcinoma gains its name because of the rapidity of growth, the clinical signs of inflammation, and most important, microscopic evidence of involvement of dermal lymphatics. The prognosis in this group is hopeless. Space does not permit discussion of other relatively rare types. (Fig. 6.)

Figure 5



Photomicrograph of a medullary carcinoma. WU 50-1419A

Figure 6



Well differentiated papillary carcinoma. Note layering of cells and central necrosis. WU 51-4214A

### Summary and Conclusion

This paper represents a study of 587 radical mastectomy specimens studied at the Ellis Fischel State Cancer Hospital, Columbia, Missouri, and at Barnes Hospital, St. Louis, Missouri.

1. The single most important factor in determining lymph node metastases is the size of the primary tumor.

2. There is little correlation between the grade of the tumor and the presence of metastases.



3. The number of lymph nodes involved is correlated with prognosis. The higher the number, the worse the prognosis. High point involvement with involvement of other node groups gives a poor prognosis.

4. The presence of nerve sheath invasion, muscle invasion, or vein invasion in conjunction with lymph node involvement makes the prognosis of a given case practically hopeless.

5. Patients with carcinoma arising in an inner quadrant with negative axillary lymph nodes will apparently have distant disease in at least half of the cases, for in 18 with no lymph node involvement only seven are living.

6. It is worth-while to dissect carefully the axilla for lymph nodes, for this study will be of value in the estimation of prognosis. An average number of 25 lymph nodes should be found.

7. A plan of therapy for operable carcinoma of the breast is proposed on the basis of the follow-up of the cases reported and the known channels of spread.

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# UTEROPLACENTAL APOPLEXY

## Case Report

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*Hammond*

**U**TEROPLACENTAL APOPLEXY was first described by Couvelaire\* in 1911 when he reported two cases of abruptio placentae in which he described the uterus as bruised, purplish and with poor power to contract and retract. Desmond in 1857 and Weis in 1894 gave the first recorded observation on this subject without recognizing the full import of their findings.

Stanley Hall<sup>2</sup> in 1943 reported a case of uterine apoplexy following an elective Cesarean section. He mentioned in his article that Portes<sup>†</sup> in 1923 collected 73 cases, and Wilson,\*\* in reviewing the World Literature in 1922, cited 69 cases, 46 of which were found at laparotomy or autopsy. Drs. Waugh and Grace<sup>‡</sup> of the Woman's Medical School in Pennsylvania reported two cases in 1947. Williams<sup>‡</sup> stated that in 83 cases of abruptio placentae treated by Cesarean section, Couvelaire's uterus which warranted hysterectomy was found in five cases. In an additional 49 cases of abruptio placentae where Cesarean sections were performed, Couvelaire changes were found in 65 percent. Stander and Adair<sup>‡</sup> report one case of uteroplacental apoplexy in every 19.1 cases of abruptio placentae. Davis and McGee<sup>†</sup> in studying 40,000 consecutive cases, found an incidence of 164 cases of abruptio placentae in varying degrees, of which fifteen showed Couvelaire changes.

Uteroplacental apoplexy is considered as an end stage of abruptio placentae and although its exact etiology is not clearly understood, it is given as that of abruptio placentae, namely: (1) toxemia of pregnancy and nephritis; (2) diseases of the ovum and endometrium; (3) trauma. The placental separation is started as effusion of blood from the decidua basalis, and at

times from alterations in the permeability of the smaller uterine vessels.

Uterine apoplexy usually occurs in women advanced in years and child-bearing. The hemorrhage may be external or internal. In concealed hemorrhage, the first symptom often consists of intense colic-like abdominal pain, and on palpation the uterus presents a board-like, almost ligneous consistency, and no longer alternates between relaxation and contraction; consequently the outline of the fetus cannot be distinguished. Occasionally the uterus enlarges and attains a size not proportionate to the age of the pregnancy. Shock does not appear until later and symptoms of acute anemia may supervene. Ligneous uterus is not always present, but when present may be considered pathognomonic. Violent movements of the fetus may be observed before any other symptom and it may mark the beginning of the placental separation. When hemorrhage is not concealed, the pain is less severe, with less enlargement of the uterus, and the consistency may or may not be changed.

Life of the mother can be saved only by prompt evacuation of the uterus, so that the organ can contract and check bleeding. Supravaginal amputation of the uterus is done as an intended operation or, upon indication, complementing the Cesarean delivery. Shock should be treated by one or more blood transfusions even before Cesarean section is performed.

With these preliminary remarks we present a case of uteroplacental apoplexy admitted to St. Margaret Hospital, Hammond, on August 30, 1951, at approximately 7:20 in the evening.

Mrs. J. S., 18 year old primigravida, married about a year, had her last menstrual period December 25, 1950, and was admitted with the chief complaint of severe abdominal pain. Not



much is known of her prenatal course as she was seen for the first time in the labor room. She did not have nausea, vomiting, headache, edema or leukorrhea during the course of her pregnancy. She states that her urinalysis had been normal and her bowels regular. She had gained thirteen pounds during pregnancy. However, she claims that she had been pale for the past few months. She observed increased fetal movements on the morning of the day of admission. A few hours prior to admission she started to have abdominal cramps, and as these became more severe she was sent to the hospital for confinement.

Her family history was noncontributory. She had menarche at the age of fifteen, regular menstrual periods at 30-day intervals of four days duration, moderate in amount and without accompanying pain.

Physical examination showed a fairly-developed, fairly-nourished, white female, very restless in bed and with marked general pallor. On further examination the uterine fundus reached to about 7 fingers above the navel. No fetal movements nor fetal heart tones could be appreciated. Fetal parts were palpable. On internal examination, the cervix was found to be elongated and without dilatation. Other physical findings were essentially normal. The patient remained restless in spite of medication. Around three hours from the time of admission, the patient was observed to be even more restless, and had cold, clammy perspiration, extreme pallor, filiform pulse of 120/min. and a B.P. of 120/80. The uterus was of board-like rigidity without any periods of relaxation. Fetal parts were no longer palpable; there was tenderness over the whole abdomen even on slight pressure; rectal examination showed an elongated cervix without any dilatation. Around six o'clock the next morning the patient had profuse vaginal bleeding.

Blood examination on admission: Type A, Rh positive, Hb. 7.9 Grams or 49.4 percent, R.B.C. 2,700,000 and C.I.O. 91.

#### Management:

(1) Sigmoidal Sodium or Sodium Secondary Amyl Bromallyl Barbiturate, Demerol, Lutin and Penicillin were given on admission.

(2) Blood transfusion, 500 cc. MS  $\frac{1}{4}$  gr., and Beclysis 1,000, were given during the night.

(3) Cesarean section followed by Porro's operation was done next morning.

(4) Plasma was given during operation.

(5) Four other blood transfusions of 500 cc. each, together with penicillin, Streptomycin, Premarin, Reticulogen and Testosterone, were administered during her postoperative period.

#### Operative Report:

Under general anesthesia a mid-rectus incision was made and the peritoneum opened. Upon inspection of the uterus, which was approximately eight months' gestation, its color was deep purple to dirty green. Its broad ligaments were also infiltrated with stasis of blood. Bladder was reflected anteriorly and a low cervical uterine incision was made. Large clots of blood, mixed with amniotic fluid, and a dead baby were found. Placenta was floating freely in the amniotic sac. Uterus was packed with sponges to determine whether the viability would return to it. After a length of time and consultation, the uterus with its broad ligaments was removed, leaving the cervix. The peritoneum was closed and muscle and fascia closed; skin approximated.

Postoperative course was uneventful except for slight elevation of temperature after operation, up to second postoperative day. On the seventh postoperative day the patient was sent home, recovered.

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# THE JOURNAL

## OF THE

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## JURY DUTY

DOCTORS are often involved in responsibilities which are not directly related to the treatment of patients. One of these responsibilities is the certification of patients' ability, on the basis of health, to perform certain duties, such as jury duty.

It may be difficult at times for the physician to determine whether a given individual's health will be impaired by his or her participation in an important civic duty such as is involved in service on a jury. Nevertheless, it is a decision which the medical profession alone is qualified to make. And, due to the fact that judicial authorities are bound to place great reliance on medical opinion in this matter, it is doubly important that good judgment and sound reasoning be utilized in the process of evolving such an opinion.

Certainly when there is genuine doubt as to the ability of the patient to participate in jury duty, the doubt should be resolved in favor of

excusing the patient. There are times, however, when a patient, who is anxious to avoid civic duties, will enlarge upon symptoms, and will take advantage of a doctor's natural inclination to please his patients, to obtain a certificate of ill health.

If this process is overdone the result may be such that a layman will be able to determine that the medical opinion is unsound, and when such certificates are presented in court, it will be evident that they are for the purpose of avoiding a moral and civic obligation.

Jury duty and all like civic obligations are extremely important in our form of government. All citizens in sound health should fulfill these duties when called upon. It is therefore essential that physicians should be equally serious when asked to recommend excuse from such duties. To be less so will lessen the validity of medical certification. Any individual worth having as a patient will respect the integrity of a doctor who refuses to issue certificates for frivolous reasons.



## HEALTH INSURANCE

THE unprecedented growth of voluntary health insurance is illustrated by the fact that there are now more than 86 million citizens of the United States who are covered by some form of health insurance.

In 1951 hospital insurance increased its membership by 12 percent. Other types of insurance, such as surgical and medical coverage which are relatively new, gained by even larger percentages. Surgical insurance was up 20 percent in 1951, and medical insurance increased by 28 percent.

Blue Shield plans form a large part of this remarkable phenomenon. There are now 78 plans with a national membership in excess of 23 million. Membership gains amount to 18,000 for every working day.

In this connection it is well to review some figures for the most important Blue Shield plan, most important, that is, for the doctors of Indiana. Mutual Medical Insurance, The Doctors' Plan for Indiana, reached a new high with slightly more than 800,000 participants in May of this year.

This represents a gain of some 220,000 members in twelve months. Indiana Blue Shield is now large enough and is organized well enough to enable it to absorb this gain efficiently and smoothly.

The cost of administration is a good yardstick by which to measure the excellence of a mutual insurance plan. The lower the administrative cost, the more money is available to be paid out on behalf of the members. Good plans have low costs, poor plans have high costs. Usually newly formed plans have higher costs originally and are able to lower expenses as they grow older and larger.

Mutual Medical boasts a figure of 11.6 percent for administrative costs for the month of May. This is significantly less than the national average of 12.46 percent for all plans in 1951. It is a very satisfactory percentage for a young plan. It indicates an implied compliment for the management of the company.

This low operative cost makes the certificates issued to its members more valuable, and increases the confidence with which the physicians of Indiana may recommend the Blue Shield plan to their patients.

## MORE POWER FROM NIAGARA

AN INTERESTING pamphlet recently was prepared by five electric power companies in New York. They are fighting a legislative proposal to create a huge federal power plant at Niagara which will furnish electricity for a wide area around New York. This is unrelated to any problem of medical care, but since it quite clearly represents an encroachment by the federal government upon free enterprise it was considered worth reviewing for the physicians in Kansas.

The United States Senate ratified a treaty with Canada in 1950 which permits the United States to utilize additional water from the Niagara River for power production purposes. Shortly thereafter Senator Lehman of New York and Representative Franklin D. Roosevelt, Jr., also of New York, proposed bills to construct such power plants from federal tax funds. The five electric power companies declared that they are in a position to build such plants quicker and cheaper without tax money and that the revenue from this power will produce additional tax income instead of reducing it as would be the case under the other proposal. They state in part, "Loss of tax revenue is a serious threat to our national income, and any project that means curtailment of tax revenue—especially when private enterprise is ready, willing and able to do the job—should be rejected." These companies claim the total public benefit would be \$40 million yearly under development by private enterprise.

The real point of this battle is that this is the first time the federal government has offered to invade the field of free enterprise for the construction of machinery solely to create electric power. In every other instance the construction has been performed on the basis of flood control, navigation, reclamation, irrigation or sanitation. This is strictly a project to provide more electric power and nothing else. This has nothing to do with the controversial St. Lawrence seaway which is 250 miles from Niagara Falls.

It is, therefore, federal invasion of the field of electric utility companies. Should the bill pass, tax money will be used for the creation of this project. The pamphlet was sent to medical societies, and the above summary is published here, to show that the problem of socialization involves

not one business or profession but all of them. Today America is no longer fighting just socialized medicine but the encroachment of socialization in all fields of enterprise. This thought is stated in the pamphlet as follows: "The issue is clear cut. Shall the government enter directly into competition with its own citizens in the production and sale of electricity? And if govern-

ment is to be permitted to nationalize the electric light and power industry, what is to prevent nationalization of other industries? Banks, for instance, transportation, the oil and steel industries, etc.? Other countries have followed that pattern, and today America is being called upon to help pay for their costly experiments."

—*Journal of the Kansas Medical Society.*

## ARE YOU REGISTERED?

Are you registered for the approaching election?

Is every member of your family of voting age also registered?

Registration may be accomplished during the month of September and any time up to October 6. All voters who did not vote in the last general election (1950) and who have not registered since then must register again to enable them to participate in the election.

All voters who have moved their place of residence are required to re-register.

It is also recommended that all citizens check their registration even though there appears to be no reason for loss of registration.

Length of residence requirements for voters are as follows: Six months in the state, 60 days in the township and 30 days in the ward or precinct.

For members of doctors' families, and for the purpose of encouraging the greatest number of voters—the age requirement is that anyone who will attain the age of 21 years by the day after the election may vote, (if properly registered).





## President's Page



NUMEROUS attempts have been made in the past to explain the high and mounting costs of medical care which the general public seems to believe is the sole responsibility of the medical profession. Some insurance advertisements refer to the expense of "Doctor's Bills" as if that were the only factor in medical care and all other services were to be grouped under the one heading.

A brief glimpse at the elevation in costs of medical care would reveal that the doctor's fees are a very small part of the total expense and also that the increase in doctors' charges has not kept pace with other costs incidental to the overall medical care.

New and expensive drugs play an important part in the increased costs of medical care but may lessen the period of illness and return the patient to his work in a shorter period of time, thereby reducing the overall costs.

According to the latest statistics physicians' incomes on the average have increased 8.5 percent to 9 percent and their fees have increased from 25 percent to 75 percent in most instances where I personally have made investigations. This should serve to refute the charges of the socializers who desire to place the high cost of medical care in the laps of the medical men and assert that compulsory health insurance would relieve the strain.

A very important factor in the cost of medical care, and one about which the doctors have very little or nothing to say, is that of hospital charges.

Within the last few years there has been a growing tendency in metropolitan areas to attempt to qualify the so-called private or non-tax-supported hospitals as teaching institutions. In so doing certain qualifications had to be met to create residencies. A number of beds were sacrificed to accomplish this purpose in areas where hospital facilities were at a low ebb. This also led to the establishment of an outpatient department, which placed the hospital in the practice of medicine. Then, too, an elaborate record system was established, much of which is an expensive outlay and of very little value. Routine laboratory examinations and mailing of reports have a minimum amount of value in the overall practice of medicine. The expense of material and subjects necessary to train a resident in a specialty must be borne by someone, and in the case of a non-tax-supported institution the private patient helps foot the bill, and like the traveling salesman's topcoat, which was not listed in his expense account, it is there just the same.

Compulsory attendance at staff meetings, which consume time and in some instances require the dispensing of food, also add to the cost of medical care and in proportion to the value to medical education or advancement can hardly be justified except as it relates to the ultimate unpopular goal of a closed staff and placing the hospitals in the practice of medicine.

Time and space will not permit enumeration of all the factors leading to hospital charges which have multiplied 300 to 500 percent in the last 40 years; however, the majority of them cannot be charged to the physicians, as the general public is led to believe.

It is to be hoped that the public relations meeting sponsored by the American Medical Association, to be held in Chicago September 4 and 5, will consider some of these problems and make some recommendations.

*J. William Wright*

## PREVIEW OF ANNUAL SESSION

**A**CKNOWLEDGED authorities from out of state and from the ranks of the Indiana State Medical Association will present papers of genuine interest for the scientific programs of the 103rd Annual Session.

The Committee on Scientific Work has arranged both general and section meetings for Wednesday, October 29, and Thursday, October 30, at which noted speakers will discuss recent advances in diagnosis and treatment in the various fields of medicine.

In addition to the general meetings, sections on medicine, surgery, ophthalmology and otolaryngology, anesthesiology, general practice, obstetrics and gynecology, preventive medicine and public health have been planned.

The complete program for the Annual Session will be carried in the October issue of THE JOURNAL. The scientific program follows:

### GENERAL MEETING

**Wednesday, October 29, 1952**

- 10:45 a.m. **John Rock, M.D.**, Boston  
*"Human Infertility"*  
 11:15 a.m. **William B. Tucker, M.D.**, Minneapolis  
*"Chemotherapy in Tuberculosis"*

### SECTION ON MEDICINE

- 2:00 p.m. **Robert L. Johnston, M.D.**, Bluffton  
*"Experience in Management of Peptic Ulcer"*  
 2:20 p.m. **Richard R. Owens, M.D.**, Muncie  
*"Functional Hypoglycemia"*  
 2:40 p.m. **Richard N. Kent, M.D.**, Fort Wayne  
*"Diagnosis of Pulmonary Emboli"*  
 3:00 p.m. **Lt. Alfred T. Chappel, M.D.**, Camp Atterbury  
*"Case of Intermittent Left Bundle Branch Block"*  
 3:20 p.m. **Glenn W. Irwin, Jr., M.D.**, Indianapolis  
*"Place of Radioactive Iodine in Thyroid Disease"*  
 3:40 p.m. **Paul J. Fouts, M.D.**, Indianapolis  
*"Recent Advances in Hematology"*  
 4:00 p.m. **Ralph C. Wilmore, M.D.**, Indianapolis  
*"Pulmonary Complications Cardio Spasm"*

### SECTION ON SURGERY

- 2:00 p.m. **Panel Discussion: "Acute Abdominal Emergencies"**  
 Moderator: **J. Stanley Battersby, M.D.**, Indianapolis  
 Participants: **Joseph B. Davis, M.D.**, Marion  
**Mell B. Welborn, M.D.**, Evansville  
**William J. Ryan, M.D.**, Columbus  
**Frauk M. Scott, M.D.**, South Bend  
 4:00 p.m. **Palmer Eicher, M.D.**, Indianapolis  
*"A New Method of Hip Replacement"*

### SECTION ON OPHTHALMOLOGY AND OTOLARYNGOLOGY

- 2:00 p.m. **Ralph J. McQuiston, M.D.**, Indianapolis  
*"Endaural Radical Masteoidectomy for Chronic Mastoiditis"*  
 2:30 p.m. **Carl J. Rudolph, M.D.**, South Bend  
*"Advantages of General Anesthesia in Ophthalmic Surgery"*  
 3:30 p.m. **Kenneth L. Craft, M.D.**, Indianapolis  
*"Allergic Dermatitis in Ophthalmology and Otolaryngology"*  
 4:00 p.m. **Edmund L. Van Buskirk, M.D.**, Lafayette  
*"Surgical Treatment of Carcinoma of the Eyelids with Plastic Reconstruction of the Eyelids"*

### SECTION ON ANESTHESIOLOGY

- 2:00 p.m. **George J. Thomas, M.D.**, Pittsburgh  
*"Fire and Explosion Hazards in Hospitals and Their Controls"*

### SECTION ON GENERAL PRACTICE

- 2:00 p.m. **Panel Discussion: "Health Insurance As It Relates to the General Practitioner"**  
 Moderator: **Maurice V. Kahler, M.D.**, Indianapolis  
 Participants: **Lester D. Bibler, M.D.**, Indianapolis  
**Walter L. Portteus, M.D.**, Franklin  
**D. D. Dickson, M.D.**, Greensburg  
**Wemple Dodds, M.D.**, Crawfordsville  
 3:00 p.m. **Maurice V. Kahler, M.D.**, Indianapolis  
*"Hospital Relationships for General Practitioners"*

### SECTION ON OBSTETRICS AND GYNECOLOGY

- 2:00 p.m. **Panel Discussion: "Obstetric Hemorrhage"**  
 Moderator: **C. O. McCormick, Sr., M.D.**, Indianapolis  
 Panel Members: **Silas H. Starr, M.D.**, Louisville  
**David L. Smith, M.D.**, Indianapolis  
**Mahlon F. Miller, M.D.**, Fort Wayne  
**Gerald W. Gustafson, M.D.**, Indianapolis  
**Pierce MacKenzie, M.D.**, Evansville  
 3:00 p.m. **Panel Discussion: "Gynecologic Hemorrhage"**  
 Moderator: **Sprague H. Gardiner, M.D.**, Indianapolis  
 Panel Members: **John Rock, M.D.**, Boston  
**Alexander W. Cavins, M.D.**, Terre Haute  
**David A. Bickel, M.D.**, South Bend  
**Carl P. Huber, M.D.**, Indianapolis  
**Frauk W. Peyton, M.D.**, Lafayette

### SECTION ON PREVENTIVE MEDICINE AND PUBLIC HEALTH

- 2:00 p.m. **Haven Emerson, M.D.**, New York  
*"Role of the Physician in Preventive Medicine and Public Health"*  
 2:30 p.m. **Panel Discussion: "Purposes and Organization of the Section on Preventive Medicine and Public Health"**  
 Participants: **Gerald F. Kempf, M.D.**, Indianapolis  
**F. R. Nicholas Carter, M.D.**, South Bend  
**Minor Miller, M.D.**, Evansville  
**L. E. Burney, M.D.**, Indianapolis  
**L. L. Reubarger, M.D.**, Marion  
**William E. Amy, M.D.**, Corydon  
 3:00 p.m. **Thomas Francis, Jr., M.D.**, Ann Arbor  
*"New Developments in Virus Diseases"*

**Thursday, October 30, 1952**

### GENERAL MEETING

- 11:00 a.m. **Paul W. Schafer, M.D.**, Kansas City, Kansas  
*"Treatment of Shock in Major Disaster Without Blood or Plasma"*  
 11:30 a.m. **Bruce K. Wiseman, M.D.**, Columbus, Ohio  
*"Problems and Dangers of Transfusion"*  
 1:30 p.m. **Victor M. Sborov, M.D.**, Washington, D. C.  
*"Infectious Hepatitis"*  
 1:50 p.m. **Arthur J. Patek, Jr., M.D.**, New York  
*"Cirrhosis of the Liver"*  
 2:10 p.m. **Robert M. Zollinger, M.D.**, Columbus, Ohio  
*"Indications for Surgery in Jaundice Patients"*  
 3:00 p.m. **Panel Discussion: "The Management of Liver Diseases"**  
 Moderator: **J. O. Ritchey, M.D.**, Indianapolis  
 Participants: **Victor M. Sborov, M.D.**, Washington, D. C.  
**Arthur J. Patek, M.D.**, New York  
**Robert M. Zollinger, M.D.**, Columbus, Ohio  
**Ralph M. Bolman, M.D.**, Fort Wayne



ORDER YOUR TICKETS FOR THE  
1952 INSTRUCTIONAL COURSES NOW!

The schedule of classes for the 1952 Instructional Courses, offered as a feature of the Annual Session of the Indiana State Medical Association, at Murat Temple, Indianapolis, is now complete. All classes are on Tuesday, October 28, 1952.  
(Attendance at these classes by members of the Indiana Academy of General Practice will be accepted as postgraduate training credit by that organization.)  
Admission to each class will be by ticket, and not more than thirty will be admitted to any class. The cost is \$1.00 per class with a maximum charge of \$3.00 for three or more classes. Plan your course to include five classes. (And please note second choices.) Enclose your check made payable to "Instructional Course Committee." Do it now! Classes are filled early!

INSTRUCTIONAL COURSE SCHEDULE

Hrs.	Room A	Room B	Room C	Room D	Room E	Room F
11 to 12	Bedside and Office Diagnosis of Cardiac and Vascular Problems. Course 1	Pediatric and Infant Feeding Problems. Course 2	The Diagnosis and Treatment of Common Skin Diseases. Course 3	The Treatment of Anemias and Allied Conditions. Course 4	Management of The Neurotic. Course 5	Constipation—Diarrhea—Indigestion. Course 6
NOON RECESS						
1 to 2	The Demonstration of a Physical and Neurological Examination. Course 7	Obstetrical Emergencies. Course 8	Bedside and Office Diagnosis of Cardiac and Vascular Problems. Course 9	Differential Diagnosis of Fatigue States. Course 10	The Treatment of Burns and Shock. Course 11	The Management of Anorectal Conditions. Course 12
2 to 3	Salt Metabolism in Heart Failure and Hypertension. Course 13	Cancer. Course 14	Shoulder and Upper Extremity Pain. Course 15	The Overactive and Inactive Thyroid. Course 16	Management of the Elderly Course 17	Diagnosis and Treatment of Respiratory Diseases. Course 18
3 to 4	The Newer Management of Coronary Disease, Rheumatic Fever and Congestive Failure. Course 19	The Diagnosis and Management of Common Gynecological Problems. Course 20	The Backache Problem. Course 21	Vertigo and Allied States. Course 22	The Diagnosis and Management of Comatose States. Course 23	The Diagnosis and Treatment of Common Skin Diseases. Course 24
4 to 5	The Newer Drugs. Course 25	Premarital and Marital Counseling. Course 26	The Headache Problem. Course 27	The Management of Diabetes Mellitus. Course 28	How to Improve Your Own Public Relations. Course 29	Office Diagnosis and Treatment of Common Genitourinary Diseases. Course 30

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Instructional Course Committee,  
Indiana State Medical Association,  
1021 Hume Mansur Building,  
Indianapolis 4, Indiana.

Enclosed find check for \$1.00; \$2.00; \$3.00. Please reserve tickets for the following Instructional Courses:

First choice.....	11:00 A.M. No.:	1:00 P.M. No.:	2:00 P.M. No.:	3:00 P.M. No.:	4:00 P.M. No.:
Second choice.....	11:00 A.M. No.:	1:00 P.M. No.:	2:00 P.M. No.:	3:00 P.M. No.:	4:00 P.M. No.:

(Insert course numbers plainly, please.)

I will pick up my tickets at the Registration Desk, October 28, 1952.

Signed: \_\_\_\_\_ M.D.  
Address: \_\_\_\_\_

Next Year Please Include \_\_\_\_\_  
Classes on These Topics \_\_\_\_\_

## ADDRESS OF THE PRESIDENT OF THE A.M.A.\*

JOHN W. CLINE, M.D.

*San Francisco*

**T**HE past year has been busy and somewhat strenuous for your president. It has carried me to many states and all parts of the country.

It has been gratifying to observe the growing unity and increasing vigor of the profession. The degree varies in the different states but the trend is apparent everywhere.

The past year represents one of great achievement in medicine. There have been important additions to our scientific knowledge and we have learned to reduce farther the latent period between the establishment of scientific fact and its practical application in diagnosis and treatment. Rapid dissemination of information by means of meetings and publications and the increased cooperative effort by investigators in common and differing fields have contributed to this process. Scientific medicine now is coordinated to a degree never previously attained.

### Medical Education

Medical education at all levels—undergraduate, graduate and postgraduate—has continued to improve. Graduate education has suffered to some degree as a result of defense mobilization and we must plan now to provide opportunity for those in the Armed Forces to complete their training when returned to civilian life.

Perhaps the most significant advance is to be found in the field of postgraduate education. More planned postgraduate courses have been offered and, in some instances, these have been carried to the physician in his home community. The attendance at meetings which have been better organized and of higher quality, has increased.

### Doctor Distribution

Medical care has increased in quantity as well as in standards. The American people enjoy

more abundant and better medical care than ever before.

The ratio of physicians to population has increased and there is better distribution of doctors. Improved transportation, better facilities and greater use of auxiliary personnel have permitted the physician to make better use of his time and render better care to more people over a wider area.

The interests of medical students in general practice and in rural practice has been fostered by the medical schools, the state associations and the American Medical Association. These efforts coupled with the placement agencies of our state and national organizations and the increased assumption of responsibility by local communities for providing medical care, have resulted in placing many physicians in areas in need of their services.

Until comparatively recently inducing physicians to locate in places needing them was considered to be solely the responsibility of the profession. It now has been demonstrated that young, well-trained physicians will go readily to communities in which they are able to practice medicine of the high quality learned during their medical school and hospital years. They will remain if the community will avail itself of their services throughout the year and if living conditions and educational facilities are adequate to provide satisfactory surroundings in which to raise a family.

There are abundant examples of success in obtaining and holding physicians when the community undertakes its portion of the burden of improving the facilities for practice and providing adequate educational opportunities for children. These serve to focus attention upon certain essential aspects of community life.

\* To the House of Delegates of the A.M.A., June 9, 1952, at Chicago.



## Medical Care Insurance

Plans for protection against the costs of illness have grown and improved during the past year. More than 85,000,000 Americans now have Blue Cross or other hospital coverage, 65,000,000 have surgical and 28,000,000 medical and surgical protection.\*

During the year, additional millions of Americans have enrolled in these programs, demonstrating that American problems can be solved by American methods and far more successfully than by resorting to government for a partial solution restricted within the rigid framework of legislation.

The multiplicity and elasticity of our plans stimulates experimentation and encourages the orderly process of evolution. This ultimately will provide us with a plan or plans which will be generally recognized as the most nearly ideal for our people.

The plans for prepayment have undergone considerable development in the past year. Coverage against economically catastrophic illness has become more general. Individual coverage is more available and experiments in covering the aged are under way. The rural population has wider protection. More must and will be done in these areas as time passes. Gaps have existed and some still exist but these are being closed.

Over the country one finds variation in the interest of the profession and the backing it gives to the voluntary insurance program. On the whole it is good and is improving.

The voluntary plans fill a great need and render a great service to our people. On this basis alone they deserve our full support. Unquestionably they are far from perfect and defects exist in some plans. Where changes are needed let us strive to bring them about in a constructive fashion.

Destructive criticism and withholding support and cooperation interfere with proper development and damage the entire program. Injury to the voluntary movement would jeopardize our future freedom.

Opinion is almost unanimous that a strong and successful voluntary insurance program is our greatest bulwark against the socialization of medicine. This opinion is held by many of our friends in other fields of endeavor and in public life. It is shared by those who would

destroy the high standards of American medicine by placing it under bureaucratic domination. Some of these belittle the accomplishments of the program and some have tried to interfere with its development because they realize that it stands as a barrier against the accomplishment of political medicine.

We have recognized and accepted our responsibilities to provide the American people with medical care of continuously improving quality and to make that care more easily available to all. We must continue our efforts.

**On the other hand, there is also growing recognition of a coexistent responsibility on the part of the public. It has been said that the plans for extension of medical care are solely the responsibility of the medical profession. It is essential that the public, the plans and the hospitals assume their portions of the burden. The provision of medical care is not a one-way street and others must meet their obligations as well.**

In the course of twenty years of dealing with medical problems on the local, state and national planes, I have watched these problems multiply and become more complex at all levels. As medical care and health have become more prominent in the minds of the people this change has been inevitable. As public interest has increased in these matters, we have come more closely under public scrutiny. As medical affairs have become more important our relations with other groups have become more important and the operations of the American Medical Association have become more important.

These activities have been strengthened in many ways. A large number of individuals have been responsible. They are too numerous even to mention at this time although I have drawn attention to some of their activities during the year through the medium of the President's Page. The headquarters staff consists of almost nine hundred loyal, hard-working employees distributed in twenty departments. With the exception of the purely organizational departments, all are working full time directly or indirectly in the public interest.

## AMA Staff

I cannot allow this opportunity to pass without paying my respects to our calm, efficient and extremely able Secretary and General Manager,

Dr. Lull, and to his very capable, energetic and loyal assistant, Dr. Howard, who direct the staff. During the past year numerous changes have been made in the interests of more efficient operations.

The quality of *The Journal* has continued to improve under the admirable direction of the Editor, Dr. Austin Smith. In my travels about the country I have heard many compliments, few criticisms of *The Journal* and almost unanimous approval of the changes he has instituted. *J.A.M.A.* has increasingly justified its reputation as the most highly respected and most widely read medical journal in the world.

The Board of Trustees is composed of fine, sincere and able men who labor arduously and with serious purposes dealing with the many matters demanding their attention. As the problems of medicine have multiplied the agendas have increased in length. It is only by close application to its work, under the capable and efficient direction of its splendid and devoted Chairman, Dr. Dwight H. Murray, that it is able to perform the many tasks assigned to it. I wish to express my deep appreciation to the Board and its Chairman for the excellent record of accomplishment of the past year.

To you, the members of the House of Delegates, I wish to express my compliments and my appreciation of the character of your deliberations. In your meetings you have considered and debated many matters. The serious responsibility of determining the basic policies of American medicine is yours. The decisions you make and the methods of expressing them are of great importance. The thought, diligence and care you have devoted to your transactions have clarified the position of medicine and have built well for the profession.

### Inter-Professional Relations

During the past year more attention has been paid to the relationship of medicine to other professions. The association with other groups concerned with the care of the sick has become closer. Problems still exist in certain areas of contact but progress has been made and is being made in dealing with them. Some will require long periods for complete solution.

No problem is too difficult to solve if patient men of good will approach it in a spirit of cooperation. An excellent example is the success-

ful conclusion of the negotiations in the establishment of the Joint Commission on Hospital Accreditation.

The medical profession and the hospitals are interdependent. What affects one affects the other. There is growing concern over mounting hospital costs and the hospitals have been unduly criticized because of them. We can do much to dispel misconceptions by explaining to our patients the reasons for this situation. About 65 percent of hospital costs are attributable to salaries and wages. As scales of compensation have risen, costs have risen correspondingly. In addition every item which the hospital must purchase is more expensive due to the spiral of inflation which involves our entire economy.

On the other hand, certain hospitals continue to engage in the practice of medicine in defiance of established principles and in contravention of the law in most states. There is, I believe, widening recognition by hospitals that the practice of medicine is the practice of medicine whether performed within or without the hospital. We recognize the right and the necessity for hospitals to derive income from certain departments staffed by physicians and ethical arrangements have been worked out whereby the rights of all concerned are respected. The hospital must not become dominant in the practice of medicine. This appears to be the objective of a small minority of administrators and trustees.

### Osteopathy

The curricula of modern osteopathic schools now are patterned largely after those of schools of medicine. The level of education provided by some has improved since the conclusion of the last war. There have been recent discussions between a committee of our Board and a similar group of the American Osteopathic Association. The representatives of the osteopathic profession express a desire for our assistance in further improving the education of students in osteopathic schools. In thirty-odd states the licenses granted to osteopathic physicians approach or approximate, for practical, legal purposes, those granted to doctors of medicine. We cannot accept or recognize the basic concept of osteopathy as a valid method of treatment of disease. The osteopathic profession apparently appreciates that fact as evidenced by the progressive reduction of the emphasis upon the



teaching of osteopathy in favor of instructions in medicine and surgery. Removal of the stigma of cultism would hasten that process.

It is my considered opinion that the AMA Council on Medical Education and Hospitals should be permitted to aid and advise schools of osteopathy and that we should facilitate the opportunities of these schools to improve their faculties by removing any barrier of unethical conduct on the part of doctors of medicine who may teach in these schools. I recommend that the House take action to implement these suggestions.

We must continue to strive for greater cooperation between medicine and the dental, nursing and pharmaceutical professions. Closer relationship will work to the advantage of all.

### Public Relations

The public relations of medicine have improved but much remains to be done. In one sense, the esteem in which medicine is held by the public is the total of the patient-physician relationships of the entire country. The good deeds of the 95 percent or more of the profession go unnoticed and are taken for granted. The transgressions of a very small proportion of physicians do untold harm to the entire profession.

Our Code of Ethics is not a body of law but is a pattern for conduct. In a sense it is the code of the gentleman in the practice of medicine. Even if it did not exist it would not be violated by many because the vast majority of our members are gentlemen.

**We have long recognized and subscribed to the dual obligation of the physician to his patient. To render to the patient the best possible medical care and to deal fairly with him in all ways. Unfortunately there are a few of our colleagues who do not respect these obligations.**

**When these are encountered they must be thrust from the company of gentlemen. There can be no compromise with dishonesty or unethical conduct. We owe forthright action not only to the public but to ourselves. Respect, to be maintained, must be deserved.**

Grievance committees have gone a long way in improving the situation but the mere existence of such committees is not enough. They must be composed of physicians who are re-

spected, not only for their professional attainments but, also, for their character, impartiality and courage. These committees must be active, easily available and the public must be informed of them and the means of access to them.

These provisions will do much to inspire public confidence. The work of these committees can be greatly reduced if the physician will discuss all aspects of his services to the patient at the outset of his contact with him. This procedure will reduce misunderstandings to a minimum and since most complaints against the profession are based upon misunderstanding these will be greatly lessened.

### Socialized Medicine

**There also has been a great change in the public position of medicine. Medicine and the American Medical Association had been subjected to years of the most vicious, systematized campaign of vilification ever waged against a respectable profession and organization devoted to the public interest. We were not prepared to meet these onslaughts. You all recall vividly the situations which confronted us in December 1948.**

**Conditions have changed. We are stronger, more unified and are better able to prevent the destruction of the high standards of medical care inevitable in socialistic schemes of its administration. Medicine has become a significant force in American life.**

The vigorous support of physicians and others throughout the country who perceived the danger to the future quality of medical care has brought about this transformation. This activity stemmed largely from the National Education Campaign so ably directed by Clem Whitaker and Leone Baxter. They deserve great credit for their splendid performance in the face of many difficulties. I wish to express the gratitude of American medicine and my own personal thanks to them for an important job well done.

When one thinks back over the period of three and one-half years and observes the change, he cannot help but be impressed. In that short time medicine has changed from an ideal whipping boy for any demagogue who wished to make a rabble rousing speech into a strong body able to respond with sufficient vigor and effec-

tiveness to make the profession an unwise object to attack.

In the long view an even greater contribution, perhaps, has been the insistence that we meet the problems confronting medicine on a positive, constructive basis and that the Association develop a strong public relations department of its own to deal with matters of fundamental importance now and in the years to come. I have described the department and its operations in a President's Page and believe it to be growing in effectiveness.

As a result of our efforts and the increasing strength of medicine, those who would destroy our capacity to render the best care to the American people have altered their strategy. As far back as the 81st Congress it was apparent that no all-inclusive bill for socialized medicine could be passed.

Our opponents realized this earlier than did we and altered their course correspondingly. They ceased the effort to overwhelm us by frontal attack and resorted to more subtle flanking maneuvers by concentrating upon the so-called fringe bills, the most important of which was federal aid to medical education. To date we have been successful in preventing legislation which would have placed the medical schools of this country in imminent danger of bureaucratic control.

### Support of Medical Schools

We recognize that our medical schools are in financial distress and we are making an effort to alleviate this situation through the American Medical Education Foundation and the National Fund for Medical Education. The results to date, this year, are more encouraging than in the first year. Every one of us owes a great debt to medical education and it must have our fullest support. Medical education is every doctor's business.

### President's Health Commission

Another manifestation of the recognition of changed conditions has been the politically inspired appointment of the President's Commission on the Health Needs of the Nation. There is adequate evidence to establish that it was created for the purpose of removing a very troublesome issue from public consideration during an election year. This

course of action was predicted by a competent observer months in advance and we now have sufficient information of the immediately preceding events to know this to be the case.

Doubt remaining in the mind of anyone concerning the political motives behind the creation of the Commission should have been dispelled by the President's recent unwarranted, undignified and intemperate attack upon the American Medical Association. It is apparent that the Administration's intention to socialize medicine has undergone no change. It is obvious that it will resort to parliamentary legerdemain to accomplish what cannot be achieved by more direct and honest methods. The angry petulance of the outburst provoked by the Association's exposure of the political trickery reveals the true colors of the Administration.

The Commission was assigned an impossible task to perform within the period of time allotted and has been described as an organization whose principal accomplishment would be to survey all pre-existing surveys to decide if additional surveys were needed. I have discussed the appointment of this body at length elsewhere.

The Board of Trustees was unanimous in denouncing its creation and the political purposes behind it. Primarily out of deference to the chairman of the Commission, the American Medical Association has made the information in its possession available to the Commission and authorized officers and employees to testify before it while completely and thoroughly disapproving of its appointment.

After such testimony has been given, by participation in panel discussions, agents of the Commission have made purported digests of the testimony. In certain instances these have ignored completely most of the statements made to the Commission. Participants have then been requested to approve or amend the distorted digests. To amend the statements adequately would require days of effort in addition to the time occupied by traveling to and from Washington and testifying. The digests have the appearance of preconceived editorialized opinions of the person or persons preparing the abstracts and do not report fairly the points of view presented to the Commission. It is obvious that this procedure is not compatible with fair presentation of the facts. I bring this situation to the



attention of the House to the end that it may be able better to evaluate the ultimate report.

In view of the magnitude of the task, the limited facilities and the short period of operation—characterized by the Commission Chairman as “too big a job for one year,” any report emanating from it must be carefully examined. It will not only be based upon inadequate time and opportunity for study but may have all the misleading and dangerous attributes of a snap diagnosis. The report may be voluminous and impressive in appearance but probably will reflect the preconceived ideas of a majority of the Commission. It must be scrutinized with great care.

### False Security

Let us not be misled by the apparent quiet of the moment. Our battle is not yet won. Complacency could well be a fatal error. I recall clearly the false security of 1946 at which time it was said that socialized medicine was “as dead as a dodo.” Two years later American medicine confronted the gravest crisis of its history.

Few persons realize the distance we have traveled, as a nation, down the road to socialism.

As physicians we know that in the course of many diseases a point is reached where the changes of structure in the tissues become irreversible and restitution of normal function becomes impossible. The disease of socialism which affects our body politic is at the present time not far from that point.

This may well be *the* year of decision. Unless the trend toward an all powerful government progressively extending its influence into our daily lives, limiting our horizons and sapping our initiative is halted, the changes in our political, economic and social structure will soon have reached the state of irreversibility. If this occurs we will have sacrificed the most precious heritage any nation ever had, and for a mess of socialistic pottage.

Medicine's firm stand has encouraged others to resist this process. At the present time we have more and stronger allies than ever before.

I urge every citizen who values the American tradition of freedom, opportunity and dignity of the individual to utmost effort this year. This may be our last chance to preserve those essential ingredients of American life.

Our leadership has inspired others. We have a great responsibility and a great opportunity. Let us not be in default.

The Third Annual Conference on Physicians and Schools will be held September 24 at the Atherton Center at Butler University. The conference is scheduled annually by the Committee on School Health and Physical Education of the Indiana State Medical Association in cooperation with the State Department of Public Instruction and the State Board of Health. Last year's conference drew more than 300.

## News Notes



SHOWN here is a part of the seven hundred farm folk who attended the fourth annual Rural Health Conference held at Purdue University, July 29. Sponsored by the Committee on Rural Health of the Indiana State Medical Association, this year's conference featured a lecture by George W. Crane, M.D., Ph.D., of Chicago, author of the newspaper column "Worry Clinic," who is shown talking to the group. Opening with a discussion on rabies, the conference drew praise from those in attendance. Planned by the Rural Health Committee the program included the following physicians: Dr. L. E. How, South Bend, Dr. John Bretz, Huntingburg, Dr. Gerald Kempf, Indianapolis, Dr. Thurman B. Rice, Indianapolis, Dr. F. S. Crockett, Lafayette, and Dr. J. William Wright, Indianapolis.

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### Hoosiers on Program of Rio Chest Congress

Four Indiana physicians, Dr. James H. Stygall and Dr. John V. Thompson, Indianapolis; Dr. Thomas R. Owens, Muncie, and Dr. J. V. Pace, New Albany, left by plane August 19 for Rio de Janeiro to attend the International Congress of Diseases of the Chest.

Doctor Stygall, vice president of the American College of Chest Physicians, was to give a paper on "Histoplasmosis of the Lung" and Doctor Thompson was scheduled to speak on "Intrathoracic Lypomas." Doctor Thompson

was also on the program of the Uruguayan chapter of the International Congress at Montevideo where he was to lecture in Spanish on "Mediastinal Tumors and Cysts."

The Indiana doctors were part of the group of 50 U. S. physicians who made the trip. Other major cities in South America were on the itinerary with visits to clinics and physicians scheduled.

The Hoosier doctors were accompanied by their wives and the party will return September 19.



## HEALTH INSURANCE PLANKS

### Republican Party Platform

We recognize that the health of our people as well as their proper medical care cannot be maintained if subject to federal bureaucratic dictation. There should be a just division of responsibility between government, the physician, the voluntary hospital, and voluntary health insurance. *We are opposed to federal compulsory health insurance with its crushing cost, wasteful inefficiency, bureaucratic dead weight, and debased standards of medical care.* We shall support those health activities by government which stimulate the development of adequate hospital services without federal interference in local administration. We favor support of scientific research. We pledge our continuous encouragement of improved methods of assuring health protection.

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### Announcement of Van Meter Prize Award

The American Goiter Association again offers the Van Meter Prize Award of Three Hundred Dollars and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The Award will be made at the annual meeting of the Association which will be held in Chicago May 7, 8 and 9, 1953, providing essays of sufficient merit are presented in competition.

The competing essays may cover either clinical or research investigations; should not exceed three thousand words in length; must be presented in English; and a typewritten double spaced copy in duplicate sent to the corresponding secretary, Dr. George C. Shivers, 100 East Saint Vrain Street, Colorado Springs, Colorado, not later than February 15, 1953.

A place will be reserved on the program of the annual meeting for the presentation of the Prize Award Essay by the author, if it is possible for him to attend. The essay will be published in the annual Proceedings of the Association.

### Democratic Party Platform

We will continue to work for better health for every American, especially our children. We pledge continued and wholehearted support for the campaign that modern medicine is waging against mental illness, cancer, heart disease and other diseases.

*Research:* We favor continued and vigorous support, from private and public sources, of research into the causes, prevention and cure of disease.

*Medical Education:* We advocate federal aid for medical education to help overcome the growing shortages of doctors, nurses, and other trained health personnel.

*Hospitals and Health Centers:* We pledge continued support for federal aid to hospital construction. We pledge increased federal aid to promote public health through preventive programs and health services, especially in rural areas.

*Cost of Medical Care:* We also advocate a resolute attack on the heavy financial hazard of serious illness. We recognize that the costs of modern medical care have grown to be prohibitive for many millions of people. We commend President Truman for establishing the non-partisan commission on the health needs of the nation to seek an acceptable solution of this urgent problem.

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### Fellowships for Basic Research in Arthritis

The Arthritis and Rheumatism Foundation is offering to qualified individuals research fellowships in the basic sciences related to arthritis. Fellowships will be granted on both the predoctoral and postdoctoral levels, and will run for one year with prospect of renewal. The predoctoral fellowships will range from \$1,500 to \$3,000 per annum depending on the family responsibilities of the fellow, and the postdoctoral fellowships will range from \$3,000 to \$6,000 on the same basis.

The deadline for applications is November 1, 1952. Applications will be reviewed and awards made by February 15, 1953. For information and application forms address the Medical Director, The Arthritis And Rheumatism Foundation, 23 West 45th Street, New York 36, N. Y.

### Observations Relating to the Use of Gamma Globulin in Prevention of Paralytic Poliomyelitis

Whether gamma globulin will be effective in the prevention of paralytic poliomyelitis is not now known. On the basis of animal experiments and preliminary study on humans, it is possible that globulin will have value in human poliomyelitis, but serious questions remain to be answered before such a hope can be substantiated. Nevertheless, public dissemination of information on the status and objectives of current studies, incompletely presented or misunderstood, has created a serious demand for gamma globulin which cannot be met.

Virtually the entire output at current production rates is required to meet the demand for prevention or modification of the course of measles and infectious hepatitis.

Under the circumstances, it is obvious that the existing limited supply and current production of gamma globulin should be reserved for use in these diseases in which its efficacy has been established.

Sub-Committee On Blood of the Health  
Resources Advisory Committee of the  
A.M.A.

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### Fiske Fund Prize Dissertation

The Trustees of the Caleb Fiske Fund of the Rhode Island Medical Society announce the following subject for the prize dissertation of 1952: "The Present Status Of Anti-Coagulant Therapy."

For the best dissertation a prize of \$200 is offered. Dissertations must be submitted by December 1, 1952, with a motto thereon, and with it a sealed envelope bearing the same motto inscribed on the outside, with the name and address of the author within. The successful author will also agree to read his paper before the Rhode Island Medical Society at its Annual Meeting on May 7, 1953. Copy must be typewritten, double spaced, and should not exceed 10,000 words. For further information write the Rhode Island Medical Society, 106 Francis Street, Providence 3, R. I.

### Fracture Association to Hear Indiana Doctors

Top-ranking specialists from throughout the United States will address the Thirteenth Annual Meeting of the American Fracture Association to be held in the Hotel Sherman, Chicago from October 6 to 9. Dr. Phillip T. Holland, Bloomington, will discuss "Hip and High Fractures of the Femur." "Complicated Fractures of the Ankle" will be discussed by Dr. Virgil McCarty, Princeton. The meeting also will feature visits to St. Luke's and Cook County Hospital clinics. Irvin H. Scott, M.D., Sullivan, is a member of the board of governors of the association.

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**Dr. A. L. Kuntz**, formerly of South Bend, has been named resident physician at the Peru Railway hospital, succeeding Dr. Harold E. Van Dyke who will enter the army soon. Dr. Kuntz is a graduate of Notre Dame and received his M. D. from Tulane University School of Medicine.

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**Dr. E. G. Dovey**, who has been practicing urology in Chicago and also serving as an associate clinical instructor at the University of Illinois and as an associate in urology at Cook County hospital, has joined Drs. L. A. and Tom Elliott in the practice of medicine in Elkhart. Dr. Dovey received his degree from Northwestern University Medical school in 1945, interned at Cook County hospital, then spent two years in the Army at Fitzsimmons General hospital, Denver, and later in Leghorn, Italy where he had charge of a urological clinic.

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Announcement has been made by **Dr. R. E. Kinneman**, Greenfield, that **Wilbur Beeson, M.D.**, who has just completed his internship at St. Vincent's hospital, Indianapolis, is now associated with him in the practice of general medicine in Greenfield. Dr. Beeson is a graduate of the Indiana University School of Medicine.

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**Earl R. Leinback, M.D.**, a graduate of Indiana University School of Medicine in 1951, began the practice of medicine in Hamlet August 1. He had just completed his internship in the Detroit Receiving Hospital.



### Medical Aspects of Civil Defense

A booklet, under the above title, has recently been published by the Council on National Emergency Medical Service of the A.M.A. The booklet consists of a series of 10 informative articles on various phases of the medical problems of civil defense. The material has been published serially in *The Journal of the A.M.A.* and is now collected for easy reference in pamphlet form. Copies may be ordered from the A.M.A. at the rate of 25 cents per single copy and 20 cents per copy in lots of 100 or more.

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**Dr. Florence M. Lyon**, who has been a practicing physician in Portland for twenty years, has closed her office to enter Ohio State University where she will take a three year course in psychiatry. She will maintain her residence in Portland.

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Two doctors will begin their professional careers in Plymouth September 1. **Dr. Harry E. Danielson, Jr.**, a native of Plymouth, and **Dr. Robert Reed**, Indianapolis, will occupy a new building, maintaining separate offices. Both are graduates of Indiana University School of Medicine and served internships at General Hospital, Indianapolis.

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**Victor W. McGinnis**, Indianapolis, has been named public relations director of the Indiana Heart Foundation. He was publicity director and field representative of the Indiana Tuberculosis Association for five years.

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**Dr. J. Theodore Luros**, who has had six years in specialty training, three in neurology and three in neuro-surgery at the University of Michigan, is now associated with **Dr. C. Basil Fausset** at 2901 North Meridian Street, Indianapolis, in the practice of neuro-surgery.

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**Donald E. Vivian, M.D.**, has assumed his post as radiologist in charge of the X-ray department of the Henry County hospital at New Castle. A graduate of Indiana University School of Medicine in 1941, Dr. Vivian spent four years as a flight surgeon with the Eighth Air Force during World War II. Following his return, he has taken special training in pathology, obstetrics and radiology at the Indiana University Medical Center.

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**Harry E. DeHaven, M.D.**, has opened an office in Manilla for the general practice of medicine and surgery. A native of West Virginia, he received his degree in 1951 from Johns Hopkins University, Baltimore.

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A veteran of eighteen years experience with the Massachusetts Department of Public Health and the Westfield State Tuberculosis Sanitorium, Westfield, Massachusetts, **Charles E. Gill, M.D.**, has recently become the fifth member of the medical staff at Irene Byron Hospital, Fort Wayne.

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**Dr. Joseph A. Miller**, graduate of Indiana University School of Medicine, 1951, has entered the practice of general medicine in Cumberland. He recently completed his internship at St. Vincent's Hospital, Indianapolis. **Dr. James Garrison**, whose office he will use in Cumberland, has entered the army for two years service.

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Attica has a new general practitioner, **Dr. Victor Gregory**, Chicago, and **Dr. James Carl Freed**, who has practised there for thirty years, has just retired. Dr. Gregory is a graduate of the University of Illinois Medical School and served his internship at St. Elizabeth's Hospital, Lafayette.

**Dr. J. E. Arata** has joined **Dr. C. G. McEachern** and **Dr. D. F. Cameron**, Fort Wayne, in the practice of general and thoracic surgery. Dr. Arata spent the last three and one-half years in Rochester, Minnesota, at the Mayo Foundation and Clinic where he had been awarded a fellowship in general and thoracic surgery.

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**Superintendent John A. Larson, M.D.** of the Logansport State hospital has announced the addition of two members to the hospital staff. **Dr. Charles Landis**, Logansport, and **Dr. John T. Ferguson**, formerly of Hamlet, will serve as resident physicians in psychiatry.

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**Dr. Margaret Jane Hitzeman**, Indianapolis, and **Dr. John Robert Ball**, resident surgeon at the Veterans Administration Hospital, Indianapolis, were married on August 16 in the Emmanuel Lutheran church, Fort Wayne. The bride received her M.D. from the Indiana University School of Medicine and has completed a year's internship at General Hospital, Indianapolis. Dr. Ball is a graduate of Jefferson Medical School, Philadelphia.

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**Dr. George R. Pullman**, formerly a general practitioner of the Cleveland Medical Foundation, is now with Murphy Medical Center at Warsaw. Dr. Pullman is a graduate of the medical school at the University of Nebraska. He was also formerly at Clarkson Hospital, Omaha, and served as a captain and adjutant of a 500-bed hospital during World War II.

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**William M. Veazey, M.D.**, who has been a practicing physician at Avilla for sixty-one years, was honored July 27 by the residents of that community with a Recognition Day program, including a parade, musical program and gift presentation. Dr. Veazey is a graduate of the School of Medicine at the University of Louisville and has spent his entire career in Avilla.

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**Dr. Donald E. Smith**, who has just completed a year's training at the Wayne County General Hospital, Detroit, has opened an office in Hope. He is a 1951 graduate of Indiana University School of Medicine.

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**Dr. Harvey Parmenter**, a native of Vincennes, has opened an office for the general practice of medicine in Sullivan. He is a graduate of the Indiana University School of Medicine and served his internship at Indianapolis General Hospital.

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**Dr. Hubert C. Peltier** has opened an office in South Bend where he will specialize in pediatrics. After graduation from the Indiana University School of Medicine, Dr. Peltier received special training in pediatrics at the James Whitcomb Riley Hospital for Children and later served in both the army and air force during World War II.

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**George P. Backer, M.D.**, graduate of the Indiana University School of Medicine in 1951 and who completed his internship June 30 at Indianapolis General Hospital, has joined his father, **H. G. Backer, M.D.**, in the practice of medicine in Ferdinand.

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When **C. G. Bothwell, M.D.**, retired August 1 after practicing medicine in Martinsville for 39 years, **John Van Weinan, M.D.** who had just completed his internship at St. Vincent's Hospital, Indianapolis, began the practice of medicine in the office occupied by Dr. Bothwell for many years. Both Dr. Bothwell and Dr. Van Weinan are graduates of the Indiana University School of Medicine.

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**Gerald G. Kring, M.D.**, a 1948 graduate of the Northwestern University Medical School, has opened an office in LaPorte where he will specialize in obstetrics. Dr. Kring interned at St. Joseph's Hospital, Chicago, did post-graduate work at the University of Illinois Medical School and has since been at St. Joseph's and St. Francis' Hospitals in Evanston.

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When **Ross Fowler, M.D.**, Bloomington, was ordered to Brooks General Hospital, San Antonio, for re-entry into the army, his practice and offices were taken over by **W. C. Link, M.D.**, who also formerly was with the U. S. Army. Dr. Link attended Indiana University and later received training at Johns Hopkins University.



## A.M.A. WASHINGTON OFFICE NEWS

**ILO Votes Social Security Treaty, Including Compulsory Health Insurance**

The International Labor Organization, meeting in Geneva, has approved a convention (treaty) on minimum standards of social security in nine fields—*Medical care*, sickness benefits, unemployment benefits, old-age benefits, employment injury benefits, family benefits, maternity benefits, invalidity benefits and survivor benefits. Approval came over objections of employer delegations from many countries. The U.S. employer spokesman was quoted as saying employers would be against the entire convention because of the medical care section alone. A government may be listed as ratifying the convention if it promises to meet the requirements in four of the nine fields of social security.

The medical care section stipulates that a country ratifying must provide a system of compulsory health insurance. Lacking this, it has two alternatives: (a) private, voluntary health insurance "administered by public authorities under established regulations" set by law, or (b) private, voluntary health insurance administered by insurance companies but under government "supervision." Coverage would have to average about 50% of the population.

Government sources agreed privately that chances of U.S. ratification were very slight at this time. *However, there is no time limit on ratification.* It was learned that the U.S. delegation had sought (a) to have the ILO conference agree that only one of the nine requirements had to be met for ratification and (b) that it be in the form of a recommendation rather than the more binding convention. The U.S. delegation voted in favor of the convention, but a spokesman for the delegation was quoted as saying this did not imply that the U.S. would accept the entire convention.

The State Department and the President will decide whether to submit the convention to the Senate for ratification. Ratification would require a two-thirds vote, which would place this country under obligation to put at least four of the nine programs in operation.

The U.S. delegates are *Senator Murray (D., Mont.)* and *Assistant Secretary of Labor Philip M. Kaiser*, representing government; *George P. Delaney of the American Federation of Labor*, representing employees, and *Charles P. McCormack, president of McCormack Tea & Spice Co.*, Baltimore, employer representative. They were assisted by a staff of 25 advisors.

**Prescription Regulations Issued in Final Form: Disputed Points Omitted.**

Food and Drug Administration, acting through the Federal Security Administrator, has issued in final form a modified series of regulations bringing federal prescription requirements into conformity with the new Durham-Humphrey Act (P.L. 215, 82nd Congress). The new regulations: 1. Provide a labeling guide to manufacturers on directions for use of drugs. 2. Continue labeling exemptions for positions. 3. Tighten up rules to make certain that prescription drugs are dispensed only by or on the prescription of a physician or other licensed practitioner. 4. Exempt certain habit-forming drugs from the prescription-only restrictions when used in non-hazardous combinations.

The new regulations are an amended version of proposed regulations published in February. However, the new ones do not attempt to rule on certain points in dispute since February. Specifically, the final regulations make no mention of prohibiting sale by mail of prescription drugs, do not attempt to define toxicity and do not apply "method of use" as a criterion for prescription-only designation (the *proposed* regulations listed all injection drugs except insulin as prescription-only).

FDA is reserving the right to rule on these controversial points in the future, but a spokesman said the agency did not wish to delay longer the official publication of regulations on which he said there is substantial agreement among the pharmaceutical industry and the medical profession.

The new regulations appear in the Federal Register for July 25 (Vol. 17, No. 145). Copies may be obtained from Food and Drug Administration, Washington 25, D. C.

## Health Commission Schedules Hearings On Voluntary-Compulsory Insurance

Hearings on the controversial question of *financing medical care* have been scheduled for October 7, 8 and 9 by the President's Commission on the Health Needs of the Nation. Exponents of all health insurance proposals will be invited to testify, including groups and individuals who have been urging adoption of the *Truman-Ewing plan for national compulsory health insurance*.

Walter Reuther, UAW-CIO president and chairman of the Commission's panel on financing of medical care, will preside over the sessions, which will be open to the press and the public. The full Commission as well as panel members will be in attendance.

During August and September the Commission has scheduled open panel meetings in eight American cities. At each a member of the Commission will preside, assisted by a chairman from the particular region. Later the Commission will study stenographic transcripts of the regional meetings before drafting its final report, which is to be presented to the White House at the end of the year. At the panels, Dr. Magnuson has asked for "*a broad representation of opinion from medical, labor, farm, consumer, educational, health and other groups*" on regional health problems. Representatives of organizations will have 10 minutes each for oral presentations, but may file briefs of any length for insertion in the official record. Individuals who wish to be heard, however, are asked to submit a written brief in advance. From these the Commissioners will select for oral presentation those considered of most value.

"We don't want to restrict the agenda to health problems we think are important," Dr. Magnuson said, "so we have decided to let the hearings run the gamut of any and all conceivable health needs."

## Federal Scholarship-Loan Program Proposed: No Action This Session

A program of federal scholarships and federally-insured loans for college students is proposed under a plan just submitted to Congress, but on which action is not asked until the next Congress convenes January 3. Under the plan medical students, among others, could be subsidized from the time of college entrance

through the last year of medical school. Federal Security Administrator Oscar Ewing said he hoped Congressional staffs would look into the proposal now and assemble information for later action. At this writing no bill has been introduced.

Amount of scholarships, determined on individual basis of need, could not exceed \$800 per year. Scholarships would cease after the student earned his first degree. Loans could not exceed \$600 per year, but would be available to graduate as well as under-graduate students. The balance could never exceed \$2,400. Repayment would be due to start during the fourth year out of school, with the balance due before end of the tenth year.

From competing high school seniors, a number would be awarded "certificates of scholarship," without consideration of need. From these lists a limited number of students who could demonstrate need would be chosen for scholarships. No academic requirements are specified for loans, other than that the student's grades be acceptable to the school.

At the national level, the U. S. Commissioner of Education would administer the program, under authority of the Federal Security Administrator. The Commissioner would by regulation establish standards for "certificates of scholarship" and scholarship checks would be drawn by the U. S. Treasury and distributed through the schools. Loan funds would be operated by the institutions themselves, with U. S. insuring 80% of each loan. A national Council on Student Aid would advise the U. S. Commissioner of Education, and State Commissions on Student Aid are provided.

## Army Hospital Construction Approved; Work Begins Early Next Year

Following final approval last week by Chief of Staff, Army Surgeon General's office announced construction will begin early next year on the first of seven permanent, modern hospitals. Plans call for completion of the multi-story structures in three years; together they will have a minimum capacity of 3,200 beds and are *designed for quick expansion during mobilization*. Five-hundred-bed hospitals expandable to 1,000 beds will be built at Fort Benning, Ga.; Fort Bragg, N. C.; Fort Knox, Ky.; and Fort Riley, Kans.; 250-bed hospital expandable



to 500, at Fort Belvoir, Va.; 200-bed hospital expandable to 300 at Fort Monmouth, N. J., and 750-bed hospital expandable to 1,000 at Fort Dix, N. J.

General Armstrong said plans prepared by leading civilian and military authorities in the hospital design field have reduced to a minimum luxuries and extras while conserving steel and other scarce materials. Findings of 3-year Army research in hospital management will be incorporated in construction, resulting in economy in use of nurses, ward technicians and other scarce personnel, General Armstrong said.

### Only More Urgent Hospital Projects to Be Considered Until Steel Supply Eases

Only the more urgent hospital and health facility projects not yet started will get any steel until the supply situation eases, probably some time early in 1953, *Office of Civilian Health Requirements* in Public Health Service states. This is an outgrowth of the steel shortage resulting from the 55-day steel strike. To take up the slack, the government plans to operate as follows: (1) third and fourth quarter allocations of steel will be honored two months beyond their allotted time, (2) first quarter allocations for 1953 will be set low enough to eliminate any remaining steel deficit, and (3) as it becomes available, new steel will be channeled into production and construction rather than going into inventories. Meanwhile, PHS has notified National Production Authority that it will require steel for 840 hospital boilers a year merely to maintain present rate of hospital construction.

Recent medical news indicates further progress in the matter of synthetic substances for the treatment of shock. Several preparations are being studied. While none of them is a substitute for whole blood or plasma, several of them are found to improve circulatory volume and can be used in cases where blood and plasma are unavailable or in limited supply. They have been variously designated as plasma volume expanders or synthetic blood extenders. The Army is now studying the use of dextran under battle conditions, and has a research team in Korea for this purpose. The Federal Civil Defense Administration is stockpiling another synthetic, PVP-Macrose, for use in civilian disasters.

## Indiana University News Notes

Thirteen additional students have been accepted for admission this fall to the School of Medicine at Indiana University, filling vacancies in the original admissions list announced last May.

Dean John D. VanNuys announced the admission of the following:

Warren R. Betty, William E. Freije, and Edgar E. Hamer, all of Indianapolis; Gordon R. Franke and Charles S. Giffin, both of Fort Wayne; Frank Chrisomalis, Bloomington; Harley J. Cronin, Hartford City; Cecil S. Manship, Marengo; John C. Parker, Wingate; John H. Schwein, Brownstown; Walter R. Springstun, Huntingburg; Peter P. Szumilas, Hammond, and Sylvester H. Pratt, Freetown, West Africa.

The new admissions bring to the capacity number of 150 those who will enter on their medical training in September.

Dr. Eugene E. Taylor, Purdue University health service physician, was named recently as university physician on the staff of the student health service at Indiana University.

A native of Arrowsmith, Illinois, Doctor Taylor is a graduate of the University of Illinois and its medical school, former professor in the Loyola University School of Medicine, and a war-time medical lieutenant colonel in the Air Force. He formerly practiced in Chicago and Bloomington, Illinois.

### Wanted: Fewer Idiots

The word *idiot* is derived from the classical Greek *idiotes*, which meant "those citizens who did not take part in public voting." In ancient Greece it was because they could not; in the United States today it is because they do not—and the word *idiot* is still appropriate.

—*Ladies' Home Journal*.

## Deaths

**Claude H. White, M.D.**, a practicing physician in Morgan county for 51 years, died suddenly on July 11 in his home in Mooresville. He was 77 years of age. Dr. White was a 1901 graduate of the Medical College of Indiana at Indianapolis. He was a former Morgan county coroner and had served as county health officer for twelve years. He was a veteran of World War I.

**George M. Schenk, M.D.**, 75, died July 19 in Ball Memorial Hospital, Muncie, after a brief illness. He had been a practicing physician and surgeon in Ridgeville for more than 50 years, serving 40 years of that time as local surgeon for the Pennsylvania railroad. Dr. Schenk was a graduate of the Eclectic Medical College, Cincinnati, in 1902.

**John P. Casper, M.D.**, who was seventy years of age, died in Sts. Mary and Elizabeth Hospital, Louisville, on July 12, following a long illness. Dr. Casper had practiced in Jasper since 1905 with the exception of a few years when he was in private practice in Louisville. He was a graduate of the Louisville School of Medicine in 1904.

**Paul V. Lynch, M.D.**, 61, died July 9 in Evansville where he had practiced medicine since 1919. Following his graduation from Indiana University School of Medicine in 1917, Dr. Lynch interned at St. Vincent's Hospital, Indianapolis, and then entered the army for two years service in the medical corps. Since 1949 Dr. Lynch had served as a psychiatrist on the staff of Evansville state hospital.

**Eugene C. Taylor, M.D.**, formerly a practicing physician in Evansville, died August 5 in Indianapolis where he had lived for the last year. After receiving his degree in medicine from the Medical College of Indiana in 1903 he was superintendent of the Boelne Tuberculosis Hospital, leaving there to establish practice in Evansville.

## Society Reports

### INDIANA STATE MEDICAL ASSOCIATION

#### THE COUNCIL

July 27, 1952

The Council of the Indiana State Medical Association convened for its summer meeting at 10:20 a.m., daylight saving time, Sunday, July 27, 1952, in the Harrison Room of the Columbia Club, Indianapolis, with Dr. Wemple Dodds, chairman, presiding. Roll call showed the following present:

#### Councilors:

First District-----Paul D. Crimm, Evansville, alternate and president-elect  
Second District-----A. G. Blazey, Washington  
Third District-----William H. Garner, New Albany  
Fourth District-----Not represented  
Fifth District-----M. C. Topping, Terre Haute  
V. Earle Wiseman, Greencastle  
Sixth District-----W. U. Kennedy, New Castle  
Seventh District-----Roy A. Geider, Indianapolis  
Don E. Wood, Indianapolis, alternate and chairman, Legislative Committee  
Eighth District-----T. R. Hayes, Muncie, alternate  
Ninth District-----Wemple Dodds, Crawfordsville  
H. E. Klepinger, Lafayette, alternate  
Tenth District-----William H. Howard, Hammond  
Eleventh District-----Elton R. Clarke, Kokomo  
Twelfth District-----M. B. Catlett, Fort Wayne  
Thirteenth District-----Kenneth L. Olson, South Bend

#### Officers:

J. William Wright, Indianapolis, president  
Roy V. Myers, Indianapolis, treasurer  
Frank B. Ramsey, Indianapolis, editor of THE JOURNAL  
C. J. Clark, Indianapolis, chairman, Executive Committee  
James A. Waggner, executive secretary  
Albert Stump, attorney  
Robert J. Amick, field secretary

#### Guests:

Wendell C. Stover, Boonville, A.M.A. delegate.  
Robert H. Rang, Washington, A.M.A., alternate delegate  
J. Neill Garber, Indianapolis, chairman, Committee on Convention Arrangements  
Maurice V. Kahler, Indianapolis, chairman, Permanent Study Committee on Medical Care Insurance  
Leroy E. Burney, Indianapolis, State Health Commissioner

On motion of Drs. Crimm and Olson, the minutes of the April 26, 1952, meeting of the Council, held at Indianapolis, were approved as printed in the June, 1952, issue of THE JOURNAL.

#### Reports of Councilors

*Doctor Blazey* called the Council's attention to a statement in the July issue of "News-vane" which said "The humbuggery of socialism and communism will never persuade our people to accept bureaucratic control of medical care. Only the doctors can do that—if they fail to make national ad-



justments of their services to the life and needs of our time." He then said that such a statement was totally fallacious, was a socialist slogan, and had no place in a piece of literature that goes out to Blue Shield clients.

On motion of Drs. Blazey and Hayes the Council voted to ask the Executive Committee of Blue Shield to scrutinize and edit the material that appears in "Newsvane" in the future.

*Doctor Topping* reported that the executive vice-president of Blue Shield had told him that the association is entitled to another member on the Board of Directors of Blue Shield and has suggested that that member could properly come from the Fifth District. On motion of Drs. Topping and Wright the Council voted to recommend Dr. Hubert T. Goodman of Terre Haute as a member of the Board of Directors of Blue Shield.

*Pre-Council meetings.* Councilors from the Second, Ninth and Eleventh districts reported that they had held pre-Council meetings with the officers of the county medical societies and the delegates in their respective districts.

Doctor Geider, Seventh District, distributed copies of the Council agenda to each of the officers and delegates in his district.

Doctor Hayes, Eighth District alternate councilor, called on each of the county societies in his district rather than having a meeting.

#### Reports of Officers

*Dr. Roy V. Myers, treasurer,* reported that since the first of the year investments in the General Fund had been increased by \$25,000.00, which was withdrawn from the General Fund checking account and invested in Series K bonds, and \$1,000.00 had been withdrawn from the Medical Defense Fund checking account and invested in the same type of bond.

*Dr. Frank B. Ramsey, editor of THE JOURNAL:* "I have two matters I want to bring to your attention. In the July issue of THE JOURNAL is published, on page 640, 'Compensation Schedule for Particular Results of Injuries,' which was prepared by the Committee on Industrial Health, of which Doctor Jones is chairman. He penciled a note on the copy, saying he thought every member of the state association should have a copy. I wondered if Doctor Jones thought we should have this reprinted and sent to each member. The cost of printing, without postage, would be \$85 or \$90. (No Council action taken, as it was pointed out in discussion that each member had a copy for reference in the annual year-book issue of THE JOURNAL.)

"Second point, Doctor Cavins and I have discussed the possibility of enlarging the staff of THE JOURNAL by electing two or three more associate editors. . . . I would like to recommend this to the members of the Council so that you might turn this over in your minds and, if you think well of

it, nominate some members so that they could take over at the first of the year when you select a new editor. I believe that retired members of the Editorial Board would be proper members to select from."

On motion of Drs. Wright and Clarke, the Council adopted Doctor Ramsey's recommendation for the election of three additional associate editors of THE JOURNAL.

#### Unfinished Business

1. *Nominations for Editorial Board.* No further nominations were made at this time. Dr. Harold D. Lynch, Evansville (pediatrics), and Dr. Carl Culbertson, South Bend (pathology), were nominated at the midwinter Council meeting.

2. *Report of Committee on Medical Education and Hospitals.* In the absence of Dr. James W. Denny, chairman, the executive secretary reported as follows:

In its campaign to raise funds for the Medical Education Foundation Fund, as of July 25, 1952, the committee had sent in to the A.M.A. \$49,765.77.

Seven hundred and seventy-eight Indiana physicians have made contributions; five out-of-state physicians have contributed \$177.00, and six organizations have contributed \$1,775.00.

Eight telephone postgraduate seminar programs have been held with good representation of the profession participating.

The committee has recorded 49 scientific lectures on tape or wire for loan to county medical societies.

This year the committee was successful in obtaining permission from the A.M.A. to record papers read at the A.M.A. meeting in Chicago.

Two states have copied the seminar program as carried out in Indiana—Kentucky and Texas.

Arrangements have been completed to record the original paper on cardiovascular diseases, which was written in 1912 by Dr. George Herrick, and which, we are told, still ranks as one of the best papers ever written on this subject.

#### Membership Matters

*Remission of state dues.* On motion of Drs. Howard and Geider, the Council voted to remit the dues of a retired Lake county member who had been certified by the secretary of that society.

#### 1952 Annual Session at Indianapolis

*Doctor Garber,* chairman of the Committee on Convention Arrangements, outlined briefly the work that has been done by his various committee chairmen.

*Publicity*—Under chairmanship of Dr. Harry Pandolfo, a dinner for the press, radio and TV people is being arranged, to be held prior to the convention, with the local medical society and the Committee on Convention Arrangements of the

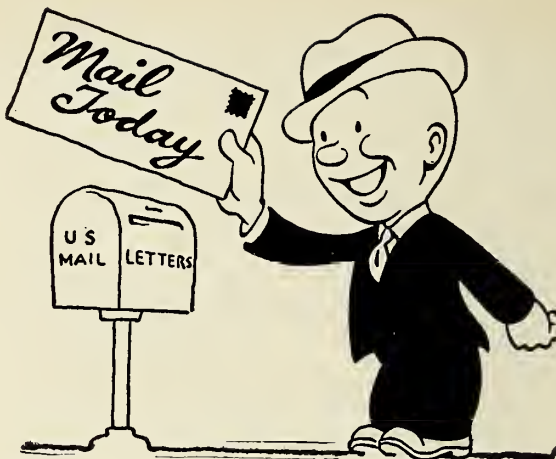
(Continued on page 926)

# Time to Make Hotel Reservation

Going to attend the annual session of the Indiana State Medical Association in Indianapolis on Tuesday, Wednesday and Thursday, October 28, 29 and 30, 1952?

It's time to make your hotel reservation.

Hotels	Rates (Start)	
	Single	Double
Antlers, 750 N. Meridian.....	\$4.25	\$6.25
Barnes, 233 McCrea Place.....	\$3.00	\$4.00
Barton, 505 N. Delaware.....	\$2.75	\$4.00
Claypool, 14 N. Illinois.....	\$4.60	\$6.30
Harrison, 51 N. Capitol.....	\$4.00	\$6.00
Jones, 248 S. Illinois.....	\$2.50	\$4.50
Lincoln, 117 W. Washington.....	\$4.50	\$6.75
Linden, 311 N. Illinois.....	\$2.00	\$3.50
Marott, 2625 N. Meridian.....	\$8.00	\$10.00
New English, 6 W. Michigan.....	\$3.00	\$5.00
Pennsylvania, 947 N. Penn.....	\$3.75	\$5.50
Riley, 155 W. 16th.....	\$2.50	\$4.50
Severin, 201 S. Illinois.....	\$4.50	\$6.50
Sheffield, 958 N. Pennsylvania.....	\$4.00	\$7.00
Spink Arms, 410 N. Meridian.....	\$3.50	\$6.00
Warren, 123 S. Illinois.....	\$4.75	\$6.75
Washington, 34 E. Washington.....	\$4.25	\$5.75



## TIME OF EVENTS

### TUESDAY, OCTOBER 28

Instructional Courses, Stag Party, Golf, Trapshoot, Party for doctors and wives.

### WEDNESDAY, OCTOBER 29

Scientific Program, entertainment at night for doctors and wives, Murat Theater.

### THURSDAY, OCTOBER 30

Scientific Program, reception for Fifty Year Club, annual dinner and dance.

### FORM FOR MAKING HOTEL RESERVATION

(Clip out this form, fill it out, and mail to hotel of your choice)

You are requested to reserve the following accommodations during the annual meeting of the Indiana State Medical Association, October 28, 29 and 30, 1952, or for such other period as may be indicated herein.

☐ Single Room with bath      ☐ Double Room with bath      Price.....  
☐ Twin Bed Room with bath      ☐ Suite

Arrival date ..... A. M. .... P. M.

Departure date ..... A. M. .... P. M.

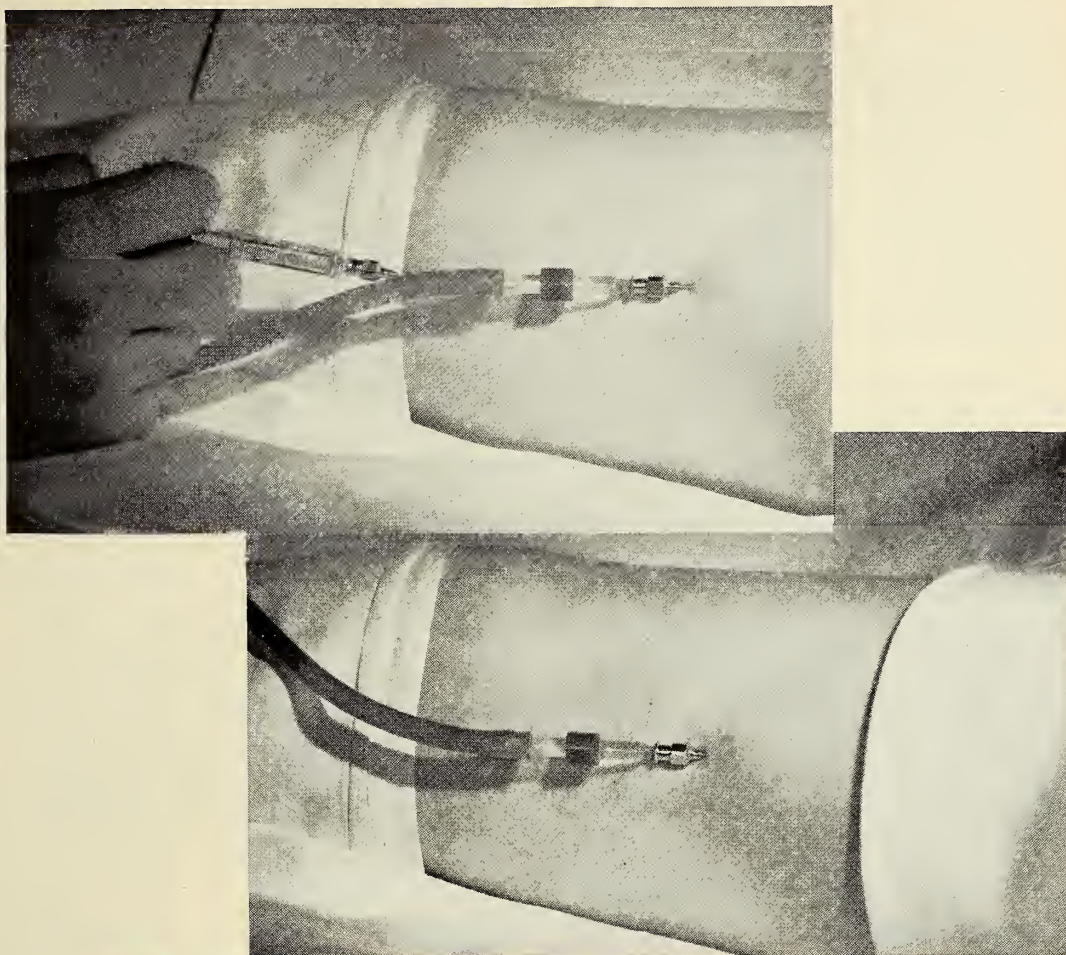
Name .....

Address .....

.....

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# SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

---

*Patronize Your Advertisers*

(Continued from page 923)

state association dividing the expense. This was done for the first time last year and was so well received that it was decided to repeat it again this year.

*Entertainment*—Tuesday morning, October 28, golf tournament at Meridian Hills, under chairmanship of Dr. Tom Brady. Trap shoot also will be held on Tuesday morning. (The Trap Shoot Committee is to be asked to make a report this year on the number who participate in order to determine whether or not this event is to be continued at future conventions.)

Tuesday night, stag dinner; combined entertainment for physicians and their wives in Murat Theater, under chairmanship of Dr. Ralph Everly.

Women physicians will hold their annual dinner Tuesday evening at the Indianapolis Athletic Club with Dr. Maxine Gibson in charge.

President's night, Wednesday, October 29, Murat Theater, with Purdue University Glee Club, is responsibility of Doctor Wright and the headquarters office.

Dr. William F. King is chairman of the Fifty-Year Club reception which will be held on Thursday, October 30.

The final party on Thursday night will be held at the Indiana Roof with appropriate entertainment and speaker. Dr. Lawson J. Clark is in charge of this event. (Speaker's time should be set down by minutes.)

*Finance*—All entertainment bills will be paid by headquarters office, with approval of Dr. Joseph Spalding, chairman of Finance, in accordance with ruling of the state Executive Committee.

*Housing*—Dr. J. E. Gillespie, chairman, and the Indianapolis Convention and Visitors Bureau will be in charge of housing.

#### New Business

1. *State Board of Health policies and program.* Doctor Burney, State Health Commissioner, said the chief problem of the State Board of Health is the retention of trained personnel. Many of the department heads have left within the last year because of greater compensation in other states.

"We have asked the clinical pathologists to appoint an advisory committee to work with the State Board of Health on problems in serology.

"There have been a number of requests from physicians for serologic work in virus diseases. The suggestion has been made that a joint program in virus work be established with the I. U. Medical Center. This will be discussed with the Serology Committee.

"We aren't entirely satisfied with our tuberculosis control program. My Board has agreed to the appointment of a study committee in this area. Specialists in chest diseases, roentgenology, general practice, and others will comprise the membership of this committee.

"The Indiana Advisory Health Council has been an active and helpful group in the last few years.

A fine group of officers has been elected this year. Dr. Joseph H. Clevenger of Muncie is chairman. The Council, in its last meeting again agreed to sponsor a bill providing financial aid to full-time local health departments. It may differ in detail from a similar bill introduced at the last session of the General Assembly. This proposed legislation is endorsed in principle by the State Board of Health.

"The Board will not propose any legislation at this coming session of the legislature. We propose to ask for (1) the same number of persons that the legislature gave us in 1951; (2) funds to allow salary increments; (3) more operating expense; (4) funds to make up approximately \$150,000 cut in federal grant-in-aid funds, on the basis that the work justifies the expenditure and that it is well for Indiana to pay a greater share of its health program."

2. *Resolution regarding Blue Shield, adopted by House of Delegates at the Interim Session, April 26, 1952, and referred back to the Council by the Executive Committee.* Mr. R. S. Saylor, executive vice-president of the Blue Shield Plan, had discussed with the Executive Committee the House of Delegates' action, requesting Blue Shield to issue split checks for services rendered by physicians and surgeons under its present indemnity schedule, and had enumerated some of the problems encountered in attempting to carry out the wishes of the House of Delegates.

Doctor Kahler, chairman of the Permanent Study Committee on Medical Care Insurance, said:

"I attended the meeting of the Board of Directors and they stated that their objection was that they felt that in some way or other they would become involved in fee splitting. I explained that we felt that such action would remove the possibility of fee splitting. At that meeting I requested a letter from Blue Shield, stating their objections to it. At the meeting I didn't get a very clear picture as to how they saw it would be fee splitting. . . .

A member of the Board felt that this fee was entirely a surgeon's fee and men who participate in the case shouldn't ask the surgeon for part of his fee. . . . It is entirely a thing between the two participating doctors, if they so desire to divide this check. I asked Mr. Waggner to communicate with the American Medical Association and the American College of Surgeons. Doctor Lull feels that it is not fee splitting, but it is a desirable thing. This is the letter from Doctor Lull:

July 3, 1952

"I believe that your House of Delegates is in keeping with the Principles of Medical Ethics when it requests the Blue Shield Plan to send two checks, one to the surgeon and one to his assistant. This is not fee splitting, provided that the bills are rendered separately and that the patient knows that the assistant is being paid a fee. Our Judicial Council has repeatedly stated that in cases of this kind separate bills should be rendered, one for the surgeon and one for the assistant. This is where the bill is rendered direct to the patient, and I

(Continued on page 928)





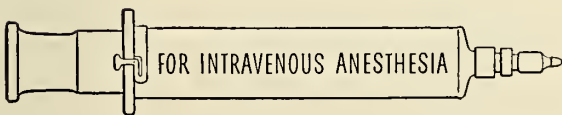
**"Actually, it has not been so much a case of PENTOTHAL Sodium's supplanting other anesthetic agents and methods as it has been of complementing and supplementing them to the mutual advantage of one another."**

Adams, R. Charles (1951), Intravenous Administration of Pentothal Sodium in Combination with Other Anesthetic Agents and Methods, J. Missouri Med. Assn., August.

IN minor and major surgery, for induction or induction and maintenance, *alone or in combination* with other anesthetics, PENTOTHAL Sodium continues to grow in popularity in operating rooms throughout the civilized world. Not without reason:

Eighteen years of experience, nearly 1900 published reports have shown that intravenous anesthesia with PENTOTHAL means a smooth, easy induction, generally without anxiety. And that deeper anesthesia may be had in a moment, as needed. Recovery is short, pleasant and usually without nausea. No bulky frightening equipment is needed. The fire and explosion hazard is eliminated. And, as it says above, this ultra-short-acting barbiturate complements and supplements other agents to "the mutual advantage of one another."

**Abbott**



**PENTOTHAL<sup>®</sup> Sodium**  
(STERILE THIOPENTAL SODIUM, ABBOTT)

(Continued from page 926)

can see no reason why, if the bill is rendered direct to the Blue Shield, this should be changed.'

"The letter and statement from the American College of Surgeons are as follows:

'7 July 1952

'Your letter of 30 June 1952, addressed to Doctor Mason, has been referred to me, since I am the Chairman of a Committee appointed by the Regents to collaborate with the National Blue Shield organization upon the very question which is the subject of your letter.

'At the meeting of the Blue Shield Commissioners in San Francisco in April of this year, I presented a request, in the name of the College, that the Commissioners consider some method by which the employment of assistants on Blue Shield cases could be on an ethical basis. The decision of the Commissioners was that they were generally sympathetic to the idea but that the initial effort should all be made at the "grass roots" level, meaning that the doctors associated with each Plan should bring the matter up and settle it individually. The Commission felt that their power and responsibility was delegated from below upward, and that they did not care to make the first steps in this movement at the upper level.

'Essentially, what I suggested in San Francisco is what is contained in the Resolution adopted by your House of Delegates, as explained in your second paragraph. It is our thought that it is entirely unrealistic to deny that the service of an assistant for a Blue Shield patient should not be compensated, and it is evident that the rules of most Plans do not make any provision for such payment. As a consequence, the surgeon is forced to split fees on these patients in order to continue to secure the services of the assistant. On the other hand, the problem is not just as simple as that, since the College has always held that referring physicians should not be used as assistants except where absolutely necessary. There are several sound reasons for this stand. We recognize the fact that if a Plan were to allow the payment of an assistant on an established fee schedule, the referring physician might sometimes be used when he would otherwise not be required. However, a real effort is being made to control this practice through hospital regulations and an abuse in this respect could certainly be controlled by the committee which is charged with approval of professional bills which are presented to the Plan.

'In general, therefore, our position is that something such as was suggested in the Resolution of your Delegates is to be recommended.

'We are enclosing a copy of a statement issued by the Regents of this College in April of this year, which is an attempt on their part to express the attitude of the College on certain unethical practices, including fee splitting. This was adopted after considerable discussion and a great deal of thought, and was designed to apply to the subject on a national basis. It is the starting point for all discussion of this matter by the administration.

Sincerely yours,

(Signed) George W. Stephenson, M.D., F.A.C.S.  
Assistant Director'

'April 15, 1952

#### 'A STATEMENT ON CERTAIN UNETHICAL PRACTICES IN SURGERY

'WHEREAS the essential of ethical financial relations in the medical profession is simple honesty, which requires the patient to be informed of the amount which is due to each physician for services rendered; and

'WHEREAS the secret division of a fee between two physicians (commonly called "fee-splitting") is dishon-

est, against the public interest, and has long been considered unethical by responsible doctors of medicine; and

'WHEREAS the payment of a referring physician by a surgeon for assistance during the operation without the knowledge of the patient, or the payment to the referring physician even with the knowledge of the patient, of an assistant's fee in excess of the amount customarily allowed for the service itself (commonly known as "inducement"), is likewise dishonest and unethical; and

'WHEREAS deception of the patient as to the identity of the physician who performs an operation (a practice known as ghost surgery) is likewise dishonest and unethical; and

'WHEREAS the overcharging of a patient by a surgeon is unjust and encourages fee-splitting; and

'WHEREAS the presentation of a combined unitemized bill by two physicians not formally associated each with the other is equivalent to fee-splitting; and

'WHEREAS an itemized combined statement designating the amount due each physician, but out of proportion in any item to individual services rendered, is equally unethical; and

'WHEREAS the payment or acceptance by physicians of rebates of fees for technical services or appliances has long been held to be unethical;

'Therefore, Be It Resolved that the American College of Surgeons make it a matter of record that it is unalterably opposed to all of the unethical practices enumerated above; and

'Be It Further Resolved that the American College of Surgeons shall foster, promote, and practice the following measures to combat unethical practices in medicine:

1. Education of the public upon the value of the services of all physicians (including surgeons), emphasizing that each should be paid adequately and directly.
2. Education of the medical student, intern, resident, and young practitioner upon the evils of unethical relations through definite instruction in medical schools, hospitals, and medical societies.
3. Education of the surgeon as to the opposition of the American College of Surgeons to exorbitant fees, the presentation of unitemized combined statements, the presentation of itemized combined statements out of proportion to individual services rendered, the payment of referring physicians used as surgical assistants or anesthetists without such payments being known to the patient, and the employment of a referring physician on a salary which is related in any way to the number of referred patients.
4. Encouragement of governing boards of hospitals, which are in any way uncertain as to the possibility of fee-splitting by a staff member, or applicant, in the adoption of the requirement for staff membership of a statement by a qualified public accountant that no evidence of unethical financial relations appears on the books of the staff member or applicant.
5. Encouragement of hospitals, which are having difficulty in identifying the responsible surgeons, in the enforcement of a regulation that the patient or his legal representative shall sign, before operation, a properly executed and witnessed permit, in which the responsible surgeon is indicated.
6. Notification to clinics and their representative organizations that the College considers placement of referring physicians on the part-time payroll of a clinic as a dangerous practice subject to strong suspicion as to ethics.
7. Punishment by expulsion of any Fellow of the College who is known to be violating the principles stated above, under Section 3, Article VIII, of the Bylaws as amended to 27 October 1950.'

(Continued on page 930)



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acute  
urinary  
tract  
infections—  
quickly...*



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CORPORATION, LTD., MONTREAL



# SULAMYD

(Continued from page 928)

"I asked Doctor Bibler to communicate with the Blue Shield official in Wisconsin and he received this letter:

July 8, 1952

"In answer to your letter of July 1 relative to Wisconsin Blue Shield plans prorating the check when more than one physician is involved on a case, may I state emphatically that it is true. I must clarify this a bit, however. We have two distinctly separate and competitive plans in Wisconsin. One is called Surgical Care and this plan is sponsored and underwritten by Milwaukee County Medical Society but is sold outside of the county at Milwaukee. It just so happens that 90 percent of the surgical and obstetrical insurance sold in my community is that of Surgical Care. There is another plan known as the Wisconsin Plan which embraces the plan of the State Medical Society; and, at the same time, all of the other private carriers who desire to underwrite insurance along the same lines and at the same rates as specified by the Wisconsin Plan. The Wisconsin Plan has not yet, to my knowledge, allowed two checks to be sent out, but, as I say, in my own particular instance as well as in many others, Wisconsin Plan Insurance is in the minority.

"The way this works is this: The two physicians, or even three as far as that is concerned, involved in a case, make up their own minds what each is to receive. Each of them are then sent blanks to fill out and each of them denotes on the blank what his fee is to be. The checks are then sent individually to the various physicians and surgeons involved in the case. It is strictly ethical, it is not fee splitting; and, in fact, it avoids fee splitting. I do not understand why those in authority cannot see that this thing called fee splitting goes on under the table anyway. You know as well as I do that Blue Shield checks, in many instances, are split. Here in Wisconsin we feel we have taken the bit in our teeth and called a spade a spade. The patient is satisfied, the insurance carrier is satisfied and the physicians are all satisfied. If there is any other information about this plan that you would like, Les, I will be very happy to give it to you and I hope that this letter will be of value to you in Indianapolis. I know the plan works and works well. I am looking forward to seeing you in September."

"As I see it, there is one objection to the two-check arrangement. It is that in instances where the total of the two claims exceeds the amount specified in the Master Plan Schedule, then the amount of the check will have to be prorated by Blue Shield. . . . This procedure has been in effect in Wisconsin for at least four years. If two doctors participate in a case, it is the desire of our committee that the doctors should determine by mutual agreement the amount of each check and fill out the return accordingly."

*The Chairman:* Doctor Kahler, didn't you say you had a communication from Blue Shield in regard to reasons why?

*Doctor Kahler:* Yes, but they didn't state any specific reasons. They said it was fee splitting but gave no specific reasons: Here is the letter:

July 15, 1952.

"The following paragraphs have been taken from the minutes of the Board of Director's meeting of this Company held on June 29, 1952:

The resolutions passed at the Interim Meeting of the House of Delegates of the Indiana State Medical Association were then taken up for consideration, particularly, the one pertaining to two checks . . .

one for the surgeon in charge and one for the general practitioner.

The subject elicited considerable discussion in which the following members of the Board took part:

Wemple Dodds, M.D.	E. S. Jones, M.D.
I. G. Barclay, M.D.	J. E. Pilcher, M.D.
E. H. Clauser, M.D.	W. L. Portteus, M.D.
Cleon A. Nafe, M.D.	W. Lawrence Daves, M.D.

Dr. Kahler, who is chairman of the Committee of the Indiana State Medical Association on Prepaid Hospital and Medical Care, also took part in the discussion.

Dr. Barclay moved that this resolution regarding two checks be referred back to the Indiana State Medical Association with the suggestion that Dr. Kahler's committee give it further study, and report to the next meeting of the Indiana State Medical Association House of Delegates; and that any further action by the House of Delegates be reported to the Board of Directors. The motion was seconded by Dr. Daves and Dr. Clark, and was unanimously carried.

"We invited Dr. M. V. Kahler to the meeting, and he participated in the discussion of this resolution.

"There was also quite a lot of interest shown with the other directors, and we thought you should have this information.

Sincerely,

MUTUAL MEDICAL INSURANCE, INC.

(Signed) R. S. Saylor

Executive Vice-President'

*Doctor Kennedy:* It seems to me that there is much ado about a comparatively simple thing. So long as we don't pay out more than the amount set in the schedule, what difference does it make to us how the doctors divide it? We already have arranged to divide the fee in accordance with the request of the principal claimant for it. Preferably we would rather continue the present method of sending out the fee to the doctor and let him settle his own affairs, and I predict that most of them will continue to do so. However, we will have the two checks made if desired, so long as the total amount does not exceed the amount allowed, and the extra cost is not great. We should not spend money that doesn't do the policyholder any good. We would like to cut down our administrative costs but we will do anything you desire in reason.

On motion of Drs. Blazey and Clarke, the Council adopted the following resolution which was presented to the Council by Doctor Kahler and which had been passed by the Permanent Study Committee on Medical Care Insurance:

"The Permanent Study Committee on Medical Care Insurance, fully discussed the objections raised by the Board of Directors of Mutual Medical Insurance, Inc., The Blue Shield Plan, to the resolution adopted by the House of Delegates of this Association on April 27, 1952, in which it was recommended that the Plan devise a method for issuing two checks, if desired, in cases of surgery where a participating physician is used. This committee communicated with the American Medical Association and the American College of Surgeons, and they inform us the proposal as made by the House of Delegates would not in their opinion constitute fee-splitting. Information has also been received from the Wisconsin Blue Shield Plan in which it is learned they follow such a system and that it has met with the approval of their physicians. In view of this information, this committee desires to re-affirm its previous resolu-

(Continued on page 932)



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\*When fed in normal quantities, provides amounts of proteins, vitamins (except C), minerals and essential unsaturated fatty acids equal to or exceeding the daily recommended allowances of The Food and Nutrition Board of the National Research Council.

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(Continued from page 930)

tion, submitted to and approved by the House of Delegates on April 27, 1952, and hereby requests the Council and the House of Delegates of this association to again approve our request that Mutual Medical Insurance, Inc., The Blue Shield Plan, devise a system of issuing a separate check to the surgeon and the participating physician, the total of the two checks not to exceed the total amount of the indemnity provided for in the Master Fee Schedule."

3. *Legislative matters* were discussed by Doctor Wood, chairman of the Committee on Public Policy and Legislation. He called attention to the insert, prepared by the Legislative Committee, in the last issue of THE JOURNAL. This will be a regular JOURNAL feature. "We hope that will meet some of the objection that was raised that our membership as a whole was not completely informed."

"We have had much closer liaison with the A.M.A. Bureau of Legal Medicine and Legislation in the past year than in any of the previous years I have been on this committee, an exceedingly good thing.

"The Legislative Committee held a meeting last Sunday. We have been asked to establish a scholarship for the training of a psychiatrist. The legislature appropriated money for several mental hospitals and now the State cannot man them. I would like to have Council action on this point."

*Psychiatric scholarships.* Following discussion by Drs. C. J. Clark, Wood, Crimm, Geider, Wright and Mr. Stump, on motion of Drs. Howard and Kennedy, the Council, as a public relations move, appropriated \$50.00 a month to each of the new mental hospitals (Beatty and Larue Carter) to set up a residency in each of these hospitals for one year.

4. *Report on AMA annual session at Chicago, June 9-13, 1952*, was read by Doctor Stover, delegate to the AMA. (Published in August, 1952, JOURNAL, pages 816 to 821.)

There being no further business, the Council adjourned to an executive session.

## EXECUTIVE COMMITTEE

July 26, 1952

Roll call showed the following present: C. J. Clark, M.D., chairman; W. L. Portteus, M.D.; J. William Wright, M.D.; Paul D. Crimm, M.D.; Wemple Dodds, M.D.; Roy V. Myers, M.D.

Frank B. Ramsey, M.D., editor of THE JOURNAL; Albert Stump, attorney; James A. Waggener, executive secretary, and Robert J. Amick, field secretary.

## Membership Report

Number of members, July 25, 1952	3,646*
Number of members, July 25, 1951	2,565
Gain over last year	81

\* Includes 76 in military service (gratis)

108—\$10.00 members (residents and interns)

244—senior members

1—honorary member

60—members, dues remitted by Council

Upon motion of Drs. Wright and Dodds, the statements of receipts and expenditures and report on the budget for June for the association and THE JOURNAL were approved.

## Headquarters Office

The executive secretary was given permission to chair a session at the National Public Relations meeting at Chicago, September 4 and 5, on motion of Drs. Wright and Myers.

1952 Annual Session, Indianapolis,  
October 28, 29 and 30, 1952:

By consent, the headquarters office was instructed to arrange for personal liability insurance, covering the Murat Temple and the Indiana Ballroom, as in the past.

By consent, it was agreed that a letter of invitation is to be sent to the dean of Indiana University School of Medicine informing him that medical students will be welcome to attend the scientific meetings of the session.

The executive secretary reported the headquarters office was following the procedure of checking exhibits with the A.M.A. to determine eligibility for display under the rules established governing displays for the 1952 session.

*Scientific exhibit.* On motion of Drs. Crimm and Portteus, the Committee approved the payment for covering tables and furnishing spot lights, in addition to other equipment for the scientific exhibits.

## House of Delegates:

a. *Meeting place.* On motion of Drs. Wright and Portteus, it was ruled that the breakfast meetings of the House of Delegates shall be held at the Athenaeum at 7:30 a.m., Tuesday, October 28, and at 7:30 a.m., on Thursday, October 30.

b. By consent, it was agreed it would be advisable to invite heads of various state organizations to attend the last session of the House of Delegates and that they be introduced to the House by the president of the association.

*Banquet guest list:* The proposed guest list for the banquet was reviewed and the executive secretary was instructed to redraft the list and bring it up for discussion at the next meeting.

In view of the fact that honoraria are being paid out-of-state speakers, on motion of Drs. Wright

(Continued on page 933)



(Continued from page 932)

and Crimm, no expenses of wives of speakers are to be paid.

### Legislative Matters

#### Local

Upon motion of Drs. Portteus and Dodds, the association is to establish a liaison with the veterans organizations, as recommended by the A.M.A., and suggested the present Veterans Committee be utilized in this respect, the final decision being left to the president of the association.

### Organization Matters

Upon motion of Drs. Crimm and Portteus, the contract with the Veterans Administration for another year was accepted as signed by Dr. W. H. Garner, chairman of the Veterans Committee. It was further suggested that an article appear in THE JOURNAL calling attention to this contract and stating that physicians who did not desire to participate so notify the Veterans Administration.

Acknowledgment from the Ferrell family was read.

Acknowledgment from the Auxiliary Editorial Board was read.

A letter from Mrs. H. T. Goodman, president of the Woman's Auxiliary, regarding advertising for *The Hoosier Doctor's Wife* was discussed, and upon motion of Drs. Wright and Crimm the Auxiliary was to be advised that the association would favor an attempt to procure advertising revenue from the voluntary health agencies rather than from pharmaceutical firms.

Request of the Committee on State Fair for permission to take blood pressures at the exhibit was approved on motion of Drs. Wright and Portteus.

Letter from the Director of Development of the World Medical Association was reviewed and the executive secretary was instructed to secure copies of the material for distribution to each member of the Executive Committee.

### The Journal

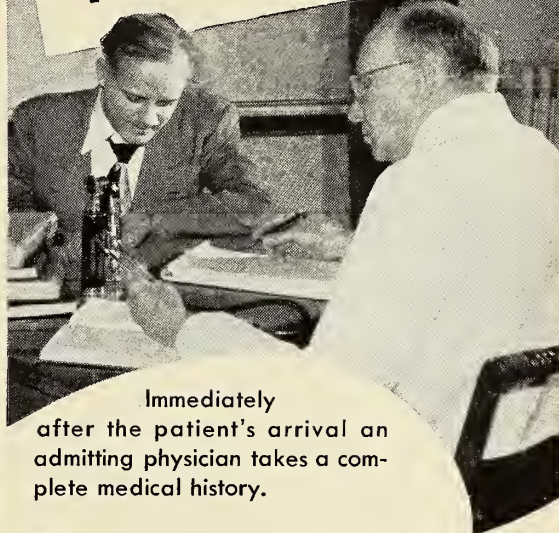
Report on advertising was accepted by consent:

Total, July, 1951 .....	\$3,027.21
Total, July, 1952 .....	2,733.66
6 months total, 1951 .....	\$13,347.67
6 months total, 1952 .....	12,534.45
Loss .....	813.22

A plan to attempt to procure more advertising for THE JOURNAL from local sources was approved on motion of Drs. Myers and Portteus.

(Continued on page 934)

## Individualized Care for the "PROBLEM DRINKER"



Immediately  
after the patient's arrival an  
admitting physician takes a com-  
plete medical history.

Treatment of the alcoholic is more than a sobering-up process; it is a rehabilitative procedure tailored to the needs of the individual.

The physicians at The Keeley Institute have had many years' experience in treating this class of patient and are specialists in their chosen field.

On arrival the patient is taken in hand by an admitting physician who obtains a complete medical history. This constitutes the first step toward instituting individualized care and treatment.

Subsequently, following a thorough physical examination and indicated laboratory studies, a detailed course of management can be outlined. It should be emphasized that no patient is continued under treatment unless he recognizes his problem and cooperates with the staff physicians.

Member, American Hospital Association  
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The Keeley Institute is accredited by the Council  
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Complete information, including rates, will be  
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**THE KEELEY INSTITUTE**  
**DWIGHT, ILLINOIS**

(Continued from page 933)

**New Business**

Upon motion of Drs. Wright and Portteus, permission was granted Dr. Earl W. Mericle to attend the Public Relations Conference in Chicago on September 4 and 5.

There being no further business, the committee adjourned to meet again at 10:00 a.m., Sunday, August 24, 1952, at the Columbia Club, Indianapolis.

**LOCAL SOCIETY REPORTS**

Montgomery County Medical Society members met in the Culver Hospital on June 19 at which time they heard a discussion on "Recent Trends in Cesarian Section."

Pike County Medical Society awarded two scholarships to candidates for nurses' training at the June meeting of the group. Two scholarships were given this year since none were awarded by the Pike county doctors in 1951. Miss Lois Corn, Odon, will train at Indianapolis General Hospital and Miss Kay Knowles, Petersburg, will enter the St. Mary School of Nursing, Evansville.

**INDIANA STATE BOARD OF HEALTH****Division of Communicable Disease Control****MONTHLY REPORT—JUNE 1952**

Disease	June 1952	May 1952	Apr. 1952	June 1951	June 1950
Chickenpox	143	356	266	82	131
Conjunctivitis	5	0	0	3	0
Diarrhea	5	3	0	0	0
Diphtheria	2	9	3	10	4
Dysentery, amebic	3	3	0	3	0
Encephalitis	6	5	0	2	4
Food infection	2	1	0	1	9
Impetigo	3	1	0	3	0
Influenza	3	9	11	23	0
Infectious hepatitis	34	21	19	20	0
Malaria	6	9	2	1	0
Measles	538	2000	1752	374	1167
Meningitis,					
Meningococcic	4	12	4	2	3
Influenzal	2	1	0	0	2
Unclassified	6	3	4	5	1
Meningococcemia	2	2	0	0	1
Mumps	158	529	462	183	74
Pneumonia	34	64	42	52	25
Polioomyelitis	19	5	1	12	5
Rabies in animals	20	14	22	63	62
Rheumatic fever	1	7	0	1	0
Rubella	58	218	138	41	39
Streptococcal infection	46	176	146	43	47
Tetanus	2	1	0	1	0
Tinea capitis	1	1	3	0	3
Typhoid fever	3	2	2	2	4
Whooping cough	30	29	34	97	137

**BOOK REVIEWS**

**PENICILLIN DECADE, 1941-1951.** By Lawrence Weld Smith, M.D., Medical Director Commercial Solvents Corporation, and Ann Dolan Walker, R.N., Former Editor "Trained Nurse and Hospital Review." 122 pages. Price \$2.50. The Arundel Press, Inc., Washington 13, D. C., 1951.

This little book is written by Doctor Lawrence Weld Smith, Medical Director of Commercial Solvents Corporation, with co-author Ann Dolan Walker, R.N., former editor "Trained Nurse and Hospital Review," and it consists of an accumulation of all major reports of sensitization and toxicities arising from the use of penicillin in one form or another. The book is conveniently arranged in sections according to the special type of sensitization or toxicity involved. Each of these sections discusses the subject and the related literature in a perfectly objective way, and is a splendid source of information for anyone who is attempting to identify types of penicillin reactions. The last section of the book consists of comments and conclusions on sensitization and toxicities in general, and, finally, a bibliography of 320 references to the main sources of information in the literature. The book is well indexed.

L.G.M.

**PRESCRIPTION FOR MEDICAL WRITING—A Useful Guide to Principles and Practice of Effective Scientific Writing and Illustration.** By Edwin P. Jordan, M.D., and Willard C. Shepard, 112 pages with 26 figures. Price \$2.50. W. B. Saunders Company, West Washington Square, Philadelphia 5, Pa. 1952.

Medical literature is so voluminous today that it must be well prepared if the author expects a publication to accept it, or a physician to read it. Unless a medical writer has unusual literary ability and experience, the assistance of some reliable book on the composition of medical papers is essential. Many good works have been published presenting the principles of English composition as applied to medical writing.

The material in this book is briefly and clearly presented and the chapter arrangement is so cleverly arranged that it adds much to the value of the book. The first chapter gives many good points on the choice of a title, collection of notes on material, and the preparation of an outline. Chapter two deals with the first draft of a paper and particularly calls attention to some important "don't's." The next three chapters discuss consecutively the three necessary revisions of a paper. A chapter is devoted to the preparation of illustrations, statistics and bibliography.

The appendices are adequate and give much useful information such as: atomic weights, equivalents of apothecary weights and measures, and equivalents of Fahrenheit and centigrade temperature recording.

This small volume compares very favorably with the other books which have been published on the subject of medical writing. Everyone doing or intending to do any medical writing should read and refer to this small volume which contains so much well condensed information.

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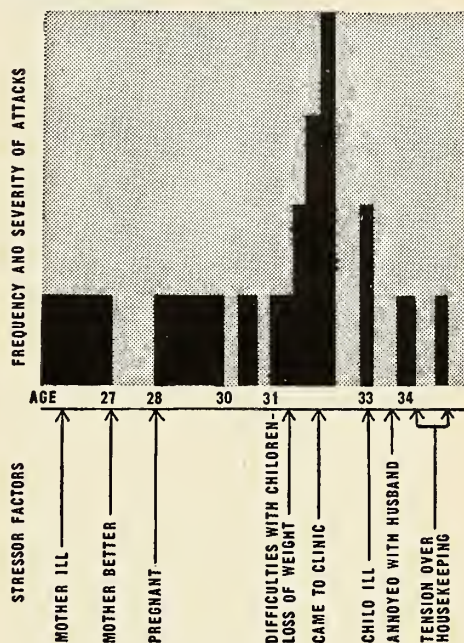
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## Stress...

Stressor factors which evoke autonomic responses occur often in our civilization. They are not always of external origin, frequently, stress springs from the "well of uncertainties, the fears, the angers, and the hostilities that an inadequate childhood nurtures in troubled people in a troubled world."<sup>1</sup>



After: Relationship Between Life Stress And Symptoms —  
Stevenson, I.: G.P. 4: 67 (Dec.) 1951

When emotions aroused by these stresses are not dissipated in appropriate biological behavior, heightened autonomic impulses beat against a "moored" physique.<sup>1</sup>

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\* Dosage of each ingredient adjusted to the needs of the particular patient.

<sup>1</sup>Cleghorn, R. A. and Graham, B. F.: *Recent Progress in Hormone Research*, Vol. IV, New York, Academic Press, Inc., 1949, p. 323.

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## *Opinions From Here and There*

**Prepared for your information by the Committee on Public Policy and  
Legislation of the Indiana State Medical Association**

**Internal Revenue Department Rules in Favor of Physicians** in an opinion stating they may now deduct from their income tax reports the payments made to others for "professional assistance" in conducting their practice. Such deduction may be made, the Bureau states in its bulletin of September 1, 1952, as an ordinary and necessary expense of carrying on a trade or business. The Bureau did not define "professional assistance."

**President's Commission Calls on Indiana.** The President's Commission on The Health Needs of the Nation has finally called on the Indiana State Medical Association to enter testimony during the regional hearing which is to be held in Detroit, Tuesday, September 23.

This may be old stuff by the time you read it, but your committee feels you might be interested in what's goin' on with regards to this. The executive secretary of our association met with representatives of Illinois, Michigan and Ohio recently in Detroit to discuss what steps the medical profession could take to force recognition of them in these hearings. A plan of attack was laid out and now your Association has an invitation to participate in these hearings.

Just 13 days prior to the scheduled date of the hearing, not one of the four state Medical Associations had received notice of the hearing or an invitation to participate, yet the hearings were concerning the Nation's Health (?). Now just 10 days away we receive an invitation and are requested to submit a brief of our presentation prior to the hearing.

This is just an example of how the Commission is evidently attempting to stifle the medical profession from participating in these hearings. Reports are to the effect that the regional meetings which have been held in the past have been packed with proponents of government "New Deal, Fair Deal" programs. We feel Dr. R. G. Averson of Frederic, Wisconsin was right when he told the hearing Commission during his testimony (which was given just 8 days following receipt of notice) the following: "The first point I make is that a one day hearing is not sufficient for an area involving 6 different states, and 10 million people. The second point is that such gross inadequacy of notice represents either an ineptness on the part of the Commission administrative staff, or an ill-considered policy on the part of the Commission."

**Press is Even Blackjacked** into running stories giving only one side of the story. To show you how cleverly the Commission has arranged these hearings, they have scheduled all the proponents of government programs,

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such as health insurance, federal aid to medical education, expanded social security programs, etc., in the morning sessions, while those giving the other side are held until the afternoon sessions. When you consider that the majority of the nation's press is printed for delivery in the evening and must have their news content gathered by noon, while the small proportion of morning papers who gather their news in the afternoon are left to report the opposing side of the hearings, the morning report then kills the material as news for the evening papers, so the majority of the public reads the side advocating all the socialistic advancements in the field of health.

The hearing will be a difficult task, but your Association and those of neighboring states have a plan they hope to put into effect which is hoped to reverse some of this so medicine's side will be heard just as widely as the proponents' side.

Chairman of the Detroit hearing will be Walter Reuther, President of the UAW-CIO. Reuther was smart, however. With the hearing in Detroit, the home of the UAW-CIO, he did not want to take all the blame for what might come out of the hearing, so he has arranged for Dr. Kenneth B. Babcock, President of the Michigan Hospital Service and Director of Grace Hospital, Detroit, to be local chairman.

We will give you a report on "Whot Hoppened", next month.

**Only About 100 Days Are Left** and we are not referring to the arrival of Santa Claus. We only wish we were. In just about 100 more days the 1953 session of the Indiana State Legislature will convene and a few headaches will be dished out to the medical profession, and the chiropractors will not be willing to cure 'em for you.

**We're Sorry** but we just have to bring it up again. The chiropractors will be back in the halls of the legislature buttonholing every Representative and Senator they can "lay their hands on", get in a room for a drink or over at the Harrison for lunch. The medical profession is not going to be discussed in a very favorable light during these lobbying conferences. You are going to be blamed for denying the public of Indiana free choice of physician, you won't permit them to make an honest living and what have you. Indications are that they will be back as strong as ever and perhaps even stronger attempting to have the state legislators feel sorry for them the way we are treating them and thereby get their board so they can hand the key to our state to all the chiros who have a diploma and 25 bucks for a license. The medical profession is going to have a fight on their hands, and this is going to require the complete cooperation of every physician. If your society does not have a copy of the story on chiropractic, showing the basis on which we are fighting to maintain the standards for the practice of the healing arts, then ask the headquarters office for a copy and discuss it fully in your society meeting. There is only one way we can fight this battle and every physician should know the story.

**Chiropractors Nearly Win** in the National American Legion Convention held recently in New York. The chiros just lacked 452 votes of having enough

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to mandate the American Legion to work in Congress for a bill requiring the Veterans Administration to use them for both in-patient and out-patient service. They keep trying and they keep getting closer, so we had better start organizing ourselves if we expect to prevent the public being victimized by a horde of questionable practitioners who claim they can cure any and all diseases.

**Another Hot One Will be Tossed at Medicine** in the coming legislature. A bill is to be introduced to change the "Workman's Compensation Act" whereby employees will have "free-choice" of physician in industrial cases.

**Labor to Support Bill** and they put up an argument which is hard for medicine to disagree with, in which they point out during all the campaign against government health insurance, we opposed Truman's program because it would deny the people free-choice of physician and would permit the government to dictate the physician to whom the public must go for care. They claim the present arrangement is just the same, because now, the employer pays for the insurance and either he or the insurance carrier designates the physician to whom the employee must go. Therefore "what's the difference" they argue. How can medicine be opposed to the government doing this and yet agree with the fact that industry has the same right?

**On the Other Hand**, management and the insurance industry will be violently opposed to the proposed change, claiming that since they purchase the insurance they should have the right to designate the physician to treat their employees. Management argues that under the old plan where the patient could go to the physician of his choice, some took advantage by overcharging, and many times it was felt proper care was not rendered at the time.

**An Attempt Will be Made to Place Medicine in the Middle** on this issue, as both sides will have arguments that will be hard to refute and which they can probably prove as our position at one time or another.

**1952 Election One of Decision** and medicine will have an important role to play. Never before has so much been at stake and every physician should take the time to acquaint himself with the issues at hand, study your candidates closely, talk to your patients, and VOTE and urge your patients to VOTE.

**This is the Year.** A warning which seems to merit thoughtful consideration by all Americans in this year of political decision was sounded recently in Youngstown, Ohio by Dr. Ernest E. Irons, a Past President of the American Medical Association.

Dr. Irons, who has been an active leader in the doctors' campaign against socialized medicine, declared that "we are still open to a flank attack through economic and business areas which have not developed an offense against continuing socialistic trends".

"The average citizen," Dr. Irons said, "can easily tell white from black in normal questions. But he shares the inability of most of us to distinguish the many shades of socialistic grey until the moral and economic issues of superficially attractive but dangerous proposals are laid bare."

This is the year for all of us to try to distinguish the basic moral and economic issues involved in all proposals affecting the future of America.

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This is the time for uncovering the socialistic hooks hidden behind a wide variety of sugar-coated baits and lures which will be proposed in the election-nearing month ahead. This is the year for us all to discern the difference between "security" and "socialism".

### **Report on Happenings in 82nd Congress:**

When second session of 82nd Congress was opened last January, it was predicted it would talk much, pass little and adjourn early. Also, that no major national health legislation would be enacted. That is the way things turned out. When it closed shop July 7, it marked the earliest adjournment date since 75th Congress folded on June 16, 1938.

In 1952, Congress considered but withheld approval of bills strengthening Federal support of local public health units; giving financial aid to medical, dental and nursing education; establishing a Department of Health. It authorized equal rights for women in medical branches of armed forces (Public Law 408); extension of \$100-a-month special pay for military physicians and dentists (P.L. 410); extension of water pollution control law to June 30, 1956 (P.L. 579)—and that is just about the story.

Out in periphery, with medical implications of one kind or another, were social security liberalization (HR 7800); amendment of Defense Housing Act (S. 3066); reorganization of reserve components of military services (HR 5426); Federal aid to Hawaii for care of leprosy cases (HR 1739); GI educational and training benefits for Korean veterans (HR 7656). These were passed and signed by the President.

With exception of appropriations measures and sundry items of extremely limited application, no other bills having any direct bearing on health sciences achieved enactment in 1952. Legislative record was even thinner than that of 1951 session of 82nd Congress, which likewise passed few important measures. Among them were Durham-Humphrey amendment of Food and Drug Act, tightening control of prescription drugs; Defense Housing and Community Facilities Act (aid for hospital expansion in critical defense areas); amendment of Selective Service Act to provide deferment equality for pharmacists, chiropractists and chiropractors.

Companion bills calling for special study of deaths and illness among American war prisoners and internees actually passed House and Senate but latter subsequently reconsidered vote and project was not enacted.

Public hearings were conducted in 1952 on a plan to revive Emergency Maternity and Infant Care program of World War II, on reorganization of Veterans Administration and on income tax relief for doctors, lawyers and other self-employed persons wishing to set up retirement annuities but adjournment placed all of them on the shelf. It is wholly probable that new legislation along same lines will be introduced after 83rd Congress convenes in January.

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### THE PROBLEM OF THE BURNED PATIENT

W. H. STEFFENSEN, M.D.

*Grand Rapids, Michigan*

HERE is no surgical problem that requires more care than the complete management of a burn. The extensive burn can develop complications involving every organ of the body. The prevention and treatment of these complications and the simultaneous care of the patient's wounds until they are healed either spontaneously or by skin grafting, plus the ultimate restoration of the individual both functionally and cosmetically to as near normal as possible constitutes a great medical and surgical challenge.

According to recent statistics almost 8,000 people die of burns every year, and half of these are children under five years of age. Death statistics tell only a fraction of the story, for it has been estimated that for every death, ten or more individuals survive to serve as constant reminders of the urgency which this problem demands.

Judgments are made by the physician who first attends the burned patient which will shorten or prolong his entire convalescence, and may even determine his death or survival. Burns vary widely in extent and character and are notoriously treacherous in this respect. It is difficult and often impossible to evaluate the surface area and depth of a burn when it is first seen and

therefore the most liberal estimation of the injury is, paradoxically, the most conservative. The appearance of the surface is only suggestively characteristic. In general, reddened or blistered areas are apt to represent partial thickness loss, while charred, dead-white, or dingy grey areas are usually full thickness. Some patients present widespread reddened or blistered areas with islands of scattered white patches of full thickness loss. The worst is to be feared in children where the skin is thin. The relation of depth and surface involvement to a possible fatal outcome is uncertain, and it must be remembered that the skin, as a vital organ, is just as damaged and functionless in a superficial burn as in a deep burn, although the subsequent healing will be rapid and complete. It is for this reason that the extensive *first* degree burn may be fatal. Any burn having a surface area of more than 5 to 8 percent (such as the greater part of a single extremity) requires the most careful and constant observation possible for at least that period of time necessary to determine the patient's reaction to his injury; and any burn involving as much as one-third of the body surface is a serious problem.

The treatment of first and second degree burns

of *minor extent* may be discussed briefly, not because they are unimportant, but because the type of care which these burns require is identical in every respect to that which is applied to the more extensive burn.

Early management of the *extensive* burn cannot be standardized. It varies from moment to moment with the progress of the patient. Treatments based on the Berkow estimation of body surface in percentages, or based on the Harkins formulae for the administration of fluids, are of more academic than practical value. Their danger lies in fostering a false security in dealing with a condition in which nothing is certain.

The patient is taken immediately to the operating room on arrival at the hospital where, with the least possible movement, clothing is cut free, and he is transferred to sterile sheets on the operating table. A preliminary investigation of the degree of shock is made usually by the determination of the pulse rate and the degree of consciousness and orientation of the patient. A very rapid inspection of the body surface is made before the patient is covered with sterile sheets and warmed blankets.

### Begin Fluids Quickly

Fluids are begun immediately. In the face of a complete peripheral vascular collapse, the immediate exposure of one or more large extremity veins is made. A peripheral blood sample is taken for determinations of the red count, hemoglobin, hematocrit and total proteins. A type and cross match is done at the same time, by the micro-method, if necessary. Large whole blood transfusions are begun at the first possible moment. Plasma is used only as a temporary substitute until whole blood can be obtained.

The use of plasma is not desirable even though it will restore lost fluids and partially replace escaping protein substances. Adequate amounts of whole blood are necessary not only to re-expand a contracted blood volume and to provide protein, but also to supply a fresh quantity of cellular elements, particularly oxygen carrying erythrocytes. The rising red blood cell count—a feature of the extensive burn, gives no indication of the oxygen carrying power of the peripheral blood from which it was taken. The patient's red cells are extensively damaged by the burn, and are rapidly destroyed by the reticulo-endothelial system. The incidence of anoxic-

anoxia and sudden establishment of profound anemia is much greater in those patients who receive plasma than in those given whole blood from the beginning of their care.

Primary attention is given to the general rather than the local condition, and not until a state of reasonable stability is reached, is the burned surface considered. An anesthetist should be available. If pain can be controlled by narcotics in ordinary dosage, preferably given intravenously, he will administer oxygen only, and keep a running record of the patient's pulse rate and blood pressure. If pain continues to be excessive, a light high-oxygen-content anesthesia is begun. Control of pain is of great importance, for induced pain adds to the degree of shock already present. Great relief of pain is experienced when the burn surface becomes dry or is covered with an adequate dressing. *The burns are then carefully washed with G 11-soap solution, blebs ruptured and loose epithelium removed.*

There are now two methods of practical value for consideration of the local management of the burn, i.e., (1) the so-called exposure method and (2) open surgical drainage pressure dressings.

The exposure method, used many years ago and revived within the past few years, appears to have some distinct advantages under strictly specified conditions. It is suitable only to areas that are not subjected to pressure. In other words it must be just what the term implies, true exposure of the burn to the air. It is therefore only practical to use it on the face, anterior portion of the neck and trunk and on portions of extremities where, when elevated, the burned surfaces will not contact the bed clothes. The success of the method is dependent upon the rapid drying of the burned surface with the formation of a crust or an eschar which seems to protect the underlying viable tissue from infection despite the fact that bacteria can be cultured from the crust or eschar itself. The patients become rapidly comfortable, show relatively little evidence of toxicity from their burn and do in some instances appear to heal more rapidly than those treated by dressing methods. This may be in part because the cases selected for this method of care are perhaps less severely burned than those treated by the dressing method. The exposure treatment requires extreme vigilance of the doctor for possible breaks in the eschar leading to infection beneath it. Third degree



burns treated by this method are ready for surgical excision of the slough by the tenth to sixteenth day in preparation for grafting.

Special attention must be paid to the hands if they are to be treated by the exposure method. If they are dressed by pressure dressings in the position of function for 48 hours, they will maintain that position during exposure until active physiotherapy can be started. If exposed from the beginning they may be flexed into extremely unphysiologic positions.

The open surgical drainage pressure dressing method consists of covering the burned surfaces with a fine-mesh gauze lightly impregnated with a bland grease, such as white petrolatum. This is followed by quantities of opened surgical sponges or plain sterile mechanic's waste which are wrapped with continuous gauze rolls. The whole dressing is then wrapped with elastic bandages which are placed firmly, but not tightly. The dressing must have sufficient bulk to allow an even distribution of gentle pressure.

### Special Dressings Indicated

The dressing of three special areas, the face, hands and perineum, deserve particular mention. The face is dressed and wrapped in just as any surface would be. An exception can be made if the burns are only first degree. The eyes and eyelids are covered, if burned, and consultation with the ophthalmologist is necessary to determine the extent of corneal and conjunctival involvement. The ears are covered with grease gauze and their contour carefully preserved beneath the dressing by packing each convolution with cotton, and filling the postauricular sulcus with cotton or gauze. The hands are carefully placed and dressed in the position of function and the fingers are separated by pieces of gauze. If the dressing is as voluminous as it should be, external splinting is usually not necessary. Because it is impractical, if not impossible to apply a pressure dressing to the genitalia and perineum, these are treated by wet dressings consisting of a thick layer of gauze which will be irrigated to saturation every two or three hours. The buttocks should always be included in the pressure dressing, and the careful placement of adhesive tape and oiled silk will prevent undue soiling.

Frequent observation of the airway, as well as the fecal and urinary outlets is made, and

immediate steps must be taken to preserve the patency of these openings if edema threatens their closure.

During the acute phase of the burn the patient is kept comfortable usually requiring sedation only. Intake and output are carefully checked, the latter being one of the most indicative criteria in the progress of the severely burned patient. A salt soda cocktail is encouraged by mouth to aid in maintaining the patient in chemical balance, supplemented by intravenous fluids and electrolyte mixtures as indicated. Only in large medical centers is it practical to chart the patient's entire electrolyte balance as compared with the normal and from a practical point of view, only a few laboratory data are necessary to insure even the severely burned patient a smooth convalescence. Basically important is a normal urinary output. An adequate amount of whole blood based upon accurate red blood cell counts and hemoglobin determinations is important although we largely disregard the factor of hemoconcentration provided the patient's clinical condition does not suggest shock. Oxygen in high concentration by tent, catheter or mask is a valuable aid in prevention and treatment of shock. Tube feeding by use of small calibre plastic tubing is of value in early establishment of physiologic nutritional balance. A high protein intake and an extremely high but balanced vitamin intake aid the patient's progress. Parenteral antibiotics are used for the first few days and tetanus prophylaxis is provided.

The salient features of the early management of a burn outlined above are continued as indicated until the course of the patient has become balanced. It may be only a matter of hours or it may be many days until this point is reached. Those patients with second degree burns offer relatively few problems to the physician compared with the third degree variety.

The initial burn dressing is best left in place five to seven days. At this time one can usually begin to distinguish between areas of second and third degree burn. If the burn surface becomes purulent as noted by elevation of temperature or dressing odor, the dressings should be changed regardless of the length of time. After the first dressing change subsequent changes should be sufficiently frequent to facilitate wound cleanliness, separation of the slough, and preparation for early grafting. This interval will usually be

every second or third day. Deep third degree burn eschar can usually be debrided surgically at 10 to 16 days. Chemical and enzymatic digestants have not yet supplanted a sharp scalpel.

If the wounds are not ready for grafting at the time of surgical debridement, the application of fine-mesh selvedged gauze over the wound and redressing for two or three days will usually find it ready for receiving a graft.

We are frequently confronted with the problem of resurfacing a long-standing chronically infected wound surface. We prepare them by using fine-mesh gauze impregnated with a water soluble bacteriocidal ointment, such as Furacin or Neomycin. The dressings are changed every second day until the surface appears reasonably clean and the patient's anemia and contracted blood volume improved sufficiently to ready them for surgery.

### Blood Requirements Fantastic

The anemia and contracted blood volume which can occur in the extensively burned, deeply burned patient is apt to escape our attention unless the patient is carefully guarded. The constant loss of body fluids through the burned surface plus the rapid destruction of red cells due to many factors inherent in the burned patient make the patient's blood requirements almost fantastic until he has been completely resurfaced. Physiologic attempts to compensate for the blood loss by contraction of the peripheral vascular bed may give one false laboratory data regarding the blood picture. It is therefore necessary to keep the blood volume "expanded" from the beginning. The patient will not be ready to withstand the surgery of resurfacing his burns nor will he grow the skin satisfactorily until his blood volume approximates the normal.

All which has been said so far has been aimed at preparation of the patient for skin grafting. Grafting can be done as soon as the slough has separated and the wound is grossly clean. In many cases this will be before the end of the third week of the burn.

It may be generalized that any patient that survives the early stages of the burn has sufficient unburned skin to use as donor areas to resurface him. A patient with more than 60 percent burn seldom lives. There are, of course, exceptions to both of these last two statements. Occasionally it may be desirable to use homo-

logous skin grafts as a temporary dressing when the patient's course seems irreversibly downhill. These will "take" and may survive from four to six weeks. If grafts are cut thin one may use the same donor area several times to completely cover an extensively burned surface. We have cut skin from the same donor area as much as four times.

The facility with which skin can now be cut is one of the factors responsible for rapid rehabilitation of the severely burned patient. We formerly had to depend upon small graft knives. Then the larger knife and suction cup was designed. Within the past few years we have been given advantage of the various dermatomes which have now been perfected to cut skin with extreme accuracy in sheets of 4" x 8" in area. Recently also we have had available an electric shaver which cuts 3" strips of skin rapidly without the use of cement from areas not accessible to the dermatomes and graft knives.

The most satisfactory result is obtained by using solid sheets of split skin sutured to completely cover the raw surface. An exception must be made where donor skin is scarce. Small squares of grafts are then utilized except over flexor surfaces but this is not a procedure of choice.

The ease with which large sheets of skin can be cut and the relative ease with which it can be grown relegate the use of pinch grafts to a method of obsolescence and definitely not a procedure of choice. In most instances the use of pinch grafts can be classified as a surgical error because of the appearance of the donor and recipient areas, their application on a thick granulation tissue base and the intervening spaces between grafts left to epithelialize which lengthen the healing time.

The patient is taken to surgery and the maximum amount of grafting is done which the patient will tolerate. This may vary from a few square inches to several 4" x 8" dermatome drums in area. Usually a graft 10-14/1000 inch in thickness is used. If after removal of a small amount of skin, his condition does not warrant the anesthetic time necessary to suture the skin into place it can be refrigerated for many days, then applied and still give a good take. The use of Dermatape with the dermatome gives one the advantage of applying sheets of skin to relatively flat surfaces without suturing them in position.



Every granulating wound resulting from a burn is an infected wound regardless of how meticulous the dressing care of that patient has been. Good aseptic care minimizes the degree of infection. Formerly we used bacteriological studies to guide us in decision of the optimum time for grafting. We now, in general, disregard the bacteriology of the wound and are guided by the patient's general condition and appearance of granulation to receive a graft. As often as is practical we remove the granulation tissue down to a firm base prior to grafting. Granulation tissue is a parasite—a protective mechanism thrown out by the patient in an abortive attempt to heal his wounds. This granulation tissue, if a graft is applied on it, becomes a scar base, and the grafted skin is less pliable than if applied on a non-granulation tissue base.

It is interesting to note that after the first procedure, although only a small amount of skin might be grafted, the patient's picture begins to change. There is something about the transplantation of skin which creates a reversal of physiological processes. Appetite improves and the patient begins to have a feeling of "well being." One cannot make actual forward progress with a burn patient from a nutritional standpoint until skin has been grafted, despite the most intensive and scientific administration of the elements lost through the burn surface or destroyed by the infection in it.

Vigilance is maintained in watching the patient's blood picture—transfusing him at frequent intervals. This permits us to return the patient to surgery for additional skin grafting at intervals of a few days to a week until all areas are covered. The patient's condition improves with each successive application of skin probably because loss of valuable body fluids diminishes in direct proportion to the area covered and replacement therapy becomes proportionately less necessary.

### Wet Dressings Aid "Take"

The use of continuous wet dressings, which has now become a routine procedure in all potentially infected surfaces which we graft, has greatly facilitated the growth of skin and the assurance of complete "takes." It is a rare instance when we fail to get a complete "take" of a graft when using wet dressings. Small multiple

perforated soft rubber tubes are incorporated in the dressings immediately outside the fine-mesh gauze covering the graft. The dressings are kept wet by instilling normal saline to the point of saturation every three hours. We have a fixed routine whereby we change the dressings three days subsequent to grafting and every second or third day thereafter. There has never been harm done from the early change of a split-skin graft dressing, but irreparable damage may result from failure to change a dressing soon enough, should there develop beneath that graft a collection of serum, or blood from one of the small vessels beneath the graft which was not completely controlled at the time of surgery.

Grafts across joint surfaces require immobilization for the period of "take," 10 to 14 days. This is usually not dangerous in children, but must be watched closely in adults. In some cases even a week of immobilization in the presence of the tissue edema and joint effusion associated with severe burns is sufficient to cause irreversible joint stiffening, particularly in hands of people past young adult life.

Active and passive motion are imperative as early as the graft will permit. Elastic bandages will have to be worn for several months on the lower extremities after the graft has healed to prevent congestion and cyanosis of the graft.

A program including graduated exercises, massage and frequently hydrotherapy, should be started in the hospital and continued throughout the office follow up. The healed graft should be kept soft by frequent application of a good skin oil.

Meticulous attention to details will accomplish maximum rehabilitation of the severely burned individual.

When a burn patient has been completely resurfaced his problems are frequently only partially solved. Despite meticulous grafting care contractures may develop over flexor surfaces of the extremities, the cervical region, around the mouth, nose and eyelids which produce distortions that are functional and cosmetic deformities of a major degree. Grafted skin applied to the face and neck offers a poor color match for surrounding normal skin in most instances. The losses, deformities and poor color matches make it imperative for the surgeon to further discharge his obligation to the patient from a cosmetic and functional rehabilitation standpoint.

# BASAL CELL CARCINOMA OF THE ANUS

CHARLES E. HALL, M.D.\*

IT IS remarkable that the basal cell variety of skin carcinoma is rarely found elsewhere than on the head, and there usually on the face above the mouth. This type of neoplasm is quite uncommon on the perineum and is even less usual about the anus. In a limited review Lott and Alexander<sup>1</sup> uncovered less than 10 cases and added one of their own. We have found published data on three additional cases (Wallon<sup>2</sup>, and Bacon<sup>3</sup>) and here report another personally encountered.

The earliest reference to the subject is an erroneous one attributed to Donald in the April, 1884 issue of the *Edinburgh Medical Journal*. It was not until almost forty years later that Pennington<sup>4</sup> briefly described an example in a 53 year old man as a granule in an anal fissure. Radium therapy was advised, but the author failed to state whether it was employed or what was the outcome of the case. Several years later Wallon<sup>2</sup> reported the condition in a male of 63 years which, as his paper is entitled, was cured by the use of radium.

Buie and Brust<sup>5</sup> recorded two cases about 20 years ago. The patients were both 53 year old women, one of whom had an advanced annular lesion. Treatment included colostomy and "posterior resection"; half of the vagina and the local lymph nodes were also removed. There was recurrence after eight and death after nine months. The other case was described as advanced and the size of an orange, with a large mass also present in the left groin. Therapy was not attempted and the outcome was not given.

In 1935, Guess<sup>6</sup> described an "early" lesion, 2 cm. in diameter, in a man of 52 years. Treatment consisted of local excision and implantation of radon seeds. The patient experienced no recurrence, but died five years after operation of coronary occlusion.

The sixth case is that of Tucker and Hellwig<sup>7</sup>, A 43 year old man was reported to have had an

"early" lesion, less than 2 cm. in diameter, the origin of which was thought to have been in a hair follicle. There was no recurrence two years after local excision and radiation therapy.

Lawrence<sup>8</sup> published two cases 11 years ago. A 73 year old man died several days after operation which involved colostomy and posterior resection of rectum and anus. The annular and fungating lesion was considered as advanced. It completely involved the anus and extended about 2 cm. into the perianal tissues. The other patient was a man of the same age who died after two years. The hard annular fungating mass, at operation, was found to include the prostate and membranous urethra. Posterior resection of the rectum and anus was combined with loop colostomy.

The ninth case of Gabriel<sup>9</sup> was diagnosed on biopsy in a 70 year old man. One year after excision by diathermy, there was no recurrence of the lesion which originally was 1-2 cm. in diameter.

The case of Lott and Alexander<sup>1</sup> manifested itself in a 62 year old woman as a "small area of thickening (1 cm.) beneath the mucosa." There was no recurrence (time of reexamination was not stated) after excision and fulguration of the base.

The last two published cases are those of Bacon<sup>3</sup>, the first of which occurred in a 60 year old man. It manifested itself by bleeding and the presence of a lump. The patient died 19 months after abdomino-perineal resection. In the other instance, a 52 year old woman had burning pain and itching as symptoms, and died nine months later despite inguinal resection and X-radiation.

An equivocal record is that of Keyes<sup>10</sup> who, in discussing 10 cases of squamous cell carcinoma of lower rectum and anus, remarks that the lesions in two cases "in some ways resembled basal cell carcinoma . . ."

## Report of a Case

The following case apparently is the eleventh to be reported. A 58 year old white janitor (50-

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4513) was admitted to the hospital June 7, 1950 because of hemorrhoids and a "granuloma" to the left of the anal opening. His chief complaints had been constipation and occasional bleeding on defecation. Proctologic examination uncovered extremely irritated skin with a "granuloma." By anoscopy, very large varices were seen; sigmoidoscopy failed to demonstrate any significant findings in the terminal 10 inches of bowel. The day following admission hemorrhoidectomy and excision of the "granuloma" were done.

At the laboratory the pertinent specimen (50-1667) was described as a flat polyp of skin, 1.5 cm. in diameter, which, on section, was largely occupied by a well circumscribed gray gelatinoid mass. The patient was free of recurrence, January, 1952.

By microscopic examination the polyp was found to be produced by a well outlined neoplasm in the cutis and subcutis (Fig. 1). In the section examined, a connection with the epidermis was not identified. The neoplasm consisted of large well delimited nests of cells resembling those of the epidermal basal layer. At the periphery of the nests there was a definite, well organized row of palisaded tall cuboidal to low columnar cells which served to outline the "lobe." Within the nests the cells were arranged in interlacing cords, 1-2 cells thick; mitosis was moderately active.

The cords and strands were separated from each other by connective tissue which, at the periphery of the nests, was relatively dense. As the centers of the nests were approached, the connective tissue became looser and demonstrated vacuolar or mucinous degeneration. The final result was almost complete loss of stroma, thus producing the effect of acini. Only the progression of regressive changes and the presence of a few fine connective tissue fibrils adjacent the cords identified the structures as false acini and not true glands. The diagnosis was "basal cell carcinoma of skin (perianal), adenoid type."

#### Comment

It is striking that the distal opening of the alimentary tract is so infrequently the site of cancer as compared to the lips. These two orifices, however, resemble each other by the predominance of squamous cell cancer; basal cell



**Figure 1.** Basal cell carcinoma of anus. The adenoid pattern is produced by mucoid change, disintegration and disappearance of stroma between the neoplastic cords. 26X.

carcinoma is virtually unknown about the lips and its existence challenged. Perhaps this state is linked to the absence of skin appendages in the lips, while their presence at the anus accounts for the rare appearance of basal cell tumors in the area. This, of course, does not explain the rarity of basal cell cancer elsewhere than on the upper part of the head.

Although only 11 cases, including our own, of anal basal cell carcinoma are recorded, the disastrous sequelae of the unrecognized or untreated condition should prompt inclusion of this lesion in the differential diagnosis of anal masses. In short, biopsy should be practiced where resection is delayed.

Metastasis in basal cell cancer is so rare as almost to be doubted. Cattell and Williams<sup>11</sup> compound the mystery in remarking, without giving references, that "Instances of metastases to the groin from an anal basal cell tumor have been reported, however."

#### Summary

A case of anal basal cell carcinoma is reported and added to 10 others collected from the literature. It is suggested that this diagnosis be included in the differential diagnosis of anal lesions, and it is urged that biopsy be substituted for procrastination.

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**The Instructional Course Curriculum and Order Blank  
are on Page 1032 of this issue.**

#### TELEPHONE SERVICE

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## DERMATITIS HIEMALIS: A REVIEW OF THE LITERATURE

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OUR interest in dermatitis hiemalis resulted from a study of the cold weather factors chapping the normal skin. (1) Dew point temperatures below 20° F., caused the horny layer of the epidermis to roughen, fissure and crumble. A smooth, soft skin, free of symptoms, could be transformed in a matter of hours into one showing all the features of a mild ichthyosis. Rough clothing meshed with the spiculated, horny mantle, readily producing a pruritic, papular dermatitis. The literature on chapping disclosed one reference (2), but the textbooks divulged accounts of a condition called pruritis hiemalis. In the light of present knowledge, it was decided to review these reports published at the turn of the century.

The first description of the actions of cold weather in producing skin disorders was written by an American dermatologist. In 1874 Duhring (3) published an account of a prevalent skin affection in Philadelphia. The name given this disorder was pruritus hiemalis. The condition appeared in the fall about the time of the first frost, varied much in degree and duration, afflicting both males and females and all age groups. Race, economic status or bathing habits made little difference. The patients were in good health. Wool clothing could not be tolerated next to the skin. Numerous treatments proved futile, but warm spring weather brought about dramatic cures.

The symptomatology was the outstanding feature of the disease. Pruritus dominated the complaints and was associated with smarting, tingling and burning. The symptoms had a sudden onset, were worse in the evening and were almost spasmodic on removing the clothing at night. Heated rooms and hot stoves intensified them. They recurred winter after winter. Glycerine was the only topical agent that produced any relief. The complaints of the patients stood out in sharp contrast to the morphology of the disease. The

only findings were a rough, harsh skin, like xeroderma or a mild ichthyosis. Some of the hair follicles were inflamed with an accumulation of epithelial debris in their orifices. Chapping was present, and in some patients a fine, hard, papular rash was found. An incidence of five per cent was found in the Philadelphia hospital and almshouse.

The disease affected the extremities, rarely involving the torso, hands, face or feet. Common sites were the non-hairy aspects of the calves of the legs. Impressed by the symptoms and the absence of a prominent morphology, Duhring believed that it was a functional derangement, unattended by a diagnostic primary eruption. This was the era in medicine when the bowel harbored all kinds of noxa. The original paper and Duhring's textbook (4) published in 1882 clearly stated that the etiology of pruritus hiemalis was due to atmospheric influences, but the condition was classified as a neurosis of the skin. Shortly after the first paper Lamadrid (5) found two cases and reproved Duhring for not recognizing the value of purging in the treatment of the disease.

Winter itching was not confined to the Atlantic seaboard. Unaware of the American report Hutchinson (6) in 1875 described a disorder in England which he named "winter prurigo." It, too, affected the extremities, but there was a tendency to cutis anserina. No primary eruption was noted, but scratching produced itchy points in which pimples developed. These were likened to seeds in the skin and were classed as true prurigo papules. Roughening and chapping were common. Complications of the disease were eczema, prurigo and ecthyma. The prurigo described by Hebra in Vienna was thought to be the same as the prurigo noted in England. In fact, the claims of Hebra in first recognizing the condition were belittled. The patients could not wear flannel; it worsened the itching. Cracks

and sores developed in the popliteal regions. Radiant heat intensified the symptoms.

### Study Temperature Effects

Epidemics of winter itching were now affecting people in the Northern Mississippi Valley. In 1885 and 1886 reports appeared by Hyde (7) on the prevalence of pruritus hiemalis. He followed the concepts of Duhring; that is, scratching produced the disease. The textbook (8) classified the condition as a sensory dermatoneurosis. The papers carried a lively, thrusting rhetoric—"The tormented skin will often retain the souvenirs of its accidents until late spring." Hyde was the first to recognize that "it was not so much the degree of coldness as it was the play of temperatures that begets the mischief to the skin." Chapping was the prominent feature of the disorder in the Middle West. These signs were not pointed out by Duhring and Hutchinson probably due to the fact that Philadelphia and England did not develop such critically low dew point temperatures. (1) Some of the patients showed a discreté or patchy papular dermatitis, and scratching produced various stages of eczema. The apices of the papules were torn or capped with blood crusts. Rubbing from coat collars, sleeves and pant cuffs evoked plentiful crops of lesions at the sites of friction. Wool was a prime inciter of the disease. Counties around Chicago had a name of their own for their particular kind of itching. Contemporary physicians believed the itching was due to scabies. Hyde defended his views and rapped a Kentucky newspaper for inferring that the winter itch in their city was due to a recent influx of Northern tramps.

Itching was still the cold weather problem in England. In 1887 Payne (9) noted that many persons suffered from itching of the skin in cold weather, especially when the air is keen, dry and frosty. They scratched when they removed their clothes at night, and some can foretell a frosty night by their sensations. Perhaps independently or from reading the reports of Hyde, Payne concluded that change of temperature more than absolute cold was the exciting cause of the dermatitis. A papular eruption limited to the extremities was the chief manifestation. This was produced by scratching and rubbing. On this basis it was suggested that the disease should be called symptomatic prurigo to differentiate it from the substantive prurigo of Hebra, where

the papules appeared to be the starting point of the disease. One of the cases was an example of pityriasis rosea of Gilbert. Keeping wool away from the patients was followed by a prompt improvement of their condition.

In 1891 Corlett (10) living in Cleveland, Ohio reported a well-defined disease, recurrent and common in cold weather. To our knowledge he was the first dermatologist to correlate the onset and exacerbations of the dermatitis with meteorological changes. In case 1, a male aged 35, the onset was November 17, 1880. A mild temperature suddenly dropped to 34° above zero; the barometer 30.21; humidity 64%; and wind N.W. The skin was rough and irritable; it "felt raw." December 14, weather was stationary, itching slight and sometimes wholly absent. February 1, 1881, temperature was 23.4°, barometer 30.6, humidity 66.4%, wind N.W. The itching was severe. Wearing silk underwear promptly mitigated the irritability of the condition. Wool, especially the cheap grades, was highly irritating to the skin. Stains on the skin from dyes used to color the wool were found. The different etiologic concepts of pruritus hiemalis were reviewed at length. Meteorological changes furnished the most likely etiology; namely, low temperatures, low humidity and wind from the northwest. These changes dried out the skin, left it harsh and easily irritated. The disease was seldom found in the southern states. Changing to a warm climate was curative.

Thus far the literature has portrayed an affection whose chief characteristic was itching. A concept was introduced or enhanced to the effect that a pruritus which prompted scratching allowed the latter to produce an eruption that was called pruritus hiemalis. This concept is widely exploited in current dermatologic literature. Many authors use it to circumvent an etiological impasse. Duhring (3) believed that pruritus hiemalis had a functional etiology. The disorder was classified in his textbook as a neurosis, and this precedent has been consistently followed. Ormsby and Montgomery (11) classed the affection as a neurosis. Their description of the disease is a brief facsimile of the original publication. The same account of the disorder was recorded by Andrews (12), Knowles, Corson and Decker (13) and by Greenbaum (14). Failure of topical therapy of the disease did not



deter one author from advocating thirty different chemicals including liberal sedation.

If the patients examined by the authors of pruritus hiemalis could be examined by present day dermatologists, the signs of xerosis and/or chapping of the skin would have gained their attention. If the patients took off shoddy, poorly dyed wool underwear and were sleeping between wool blankets, a wool dermatitis would have been considered. Low dew point temperatures disrupt and spiculate the horny mantle. Red flannels were the vogue at the turn of the century, and to this day they are synonymous with keeping warm. One wonders if at this time an enterprising manufacturer was dyeing or processing the wool or adulterating it to build up its itching properties. Contemporary physicians did not accept the etiology of pruritus hiemalis, believing instead that such severe itching must be caused by animal parasites. Interpreting pruritus hiemalis as due to an atmospheric desiccation of the skin followed by irritation from wool would not justify classifying the disease as a neurosis, and it would refute the concept of the three 'ings'—itching, scratching, erupting—in its causation. Hyde (7) and Payne (9) were first to recognize that sudden changes in temperature placed an unusual stress on the horny layer of the epidermis.

### Case Histories Reported

The year 1894 may or may not become a dermatologic landmark. Instead of pruritus receiving the attention in cutaneous affections of cold weather, morphology was given the emphasis. Hutchinson (15) described a patient with catarrhal dermatitis on the backs of the hands from cold weather. The same year Corlett (16) reported his studies on fourteen cases of eczema of the hands to which he gave the name, dermatitis hiemalis. Three meteorological conditions were essential for its appearance: 1) low temperatures; 2) low humidity; and 3) air in motion. Storms aggravated the disease. Males predominated because of more exposure to cold weather. Social status or occupation had no influence. Chilblains did not predispose. Prominent among the morbid changes in the skin was the dusky, almost cyanotic appearance of the lesion, which changed in tint accordingly as the position of the hand was raised or dependent. The tint was also influenced by the temperature of the

room. The dermatitis has the following distinctive features:

1. It appears suddenly at the approach of cold weather.
2. A spontaneous involution occurs in the spring.
3. It has the liability to return in successive years, occupying sites previously involved.
4. Its chief locations are the backs of the hands and fingers, wrists and forearms.
5. The disease shows little tendency to spread after the lesions are fully developed.
6. It is characterized by: a) vesicles which easily rupture leaving denuded, weeping, irregular pin-head to lentil-sized surfaces with a raw ham tint; b) variously sized, round or horseshoe-shaped patches, which are slightly or markedly thickened, having an abrupt, well-defined margin and a dusky red color; c) patches which fade to a rose color as involution proceeds, becoming covered with a thin layer of adherent scales, which may mark the subsidence of the attack.
7. Itching may or may not be present. When present it is paroxysmal.
8. The eruption is not associated with any other disease, nor is it due to any organic disease.

Treatment was not effective. The dermatitis disappeared in warm weather or during a trip to Florida. This report was not well received by dermatologists. They labeled the disease, ringworm. In 1896 before the International Dermatological Congress (17) in London, four more cases were presented. H. S. Lipson was unable to find saprophytic organisms in lesions. Hyde was criticized by those who believed the itch meant animal parasites, and now Corlett was attacked by those who believed that all rashes on the hands must be due to vegetable parasites.

In spite of little support, Corlett labored to clinically establish the disease entity, dermatitis hiemalis. In 1902 (17) he published an additional twelve cases of hand eczema from meteorological changes. Histological changes in the lesions were correlated with meteorological events. Epidermal vesicles develop with edema and separation of the rete mucosum. The upper

cutis showed edema, dilatation of vessels and has a slight cellular infiltrate. This paper brought out considerable discussion. W. L. Gottheil claimed the disease was a mycotic eczema; M. B. Hartzell said it was not mycotic.

The fourth contribution was by Corlett and Cole (18). It opened with these sentences: "The skin from its exposed condition is more influenced by conditions such as climate etc., than are other organs of the body. Many diseases of the skin are limited to certain equatorial zones and others are greatly modified by climate." This paper confirmed that additional examinations for vegetable parasites had invariably given negative results. Gram stains of the tissues in the latter stages of the disease have shown numerous gram positive cocci; but these were classed as secondary invaders. Weather charts were shown pointing out the extreme variability of winter weather, including wind changes, in the Great Lakes region.

Histologic studies were made of the various stages of the disease. Some excellent photomicrographs are shown. On the basis of meteorological, clinical and histological features, the following explanation was proposed by the authors:

Given a susceptible person, the variable, wintry, windy weather, as met within the Great Lakes region of North America, causes an irritation of the skin of the hands. This first results in a slight vascular dilatation of the vessels of the papillae. The endothelial cells lining the vessels swell up, and if the condition continues there will result the extravasation of some serum from these vessels into the papillary tissue. Possibly a few polymorphonuclear leukocytes will also find their way into the surrounding tissues. The irritation still continuing, there will be a constantly increasing vascular dilatation. With a larger amount of serum being poured out, it will gradually work out through the lymph channels of the epidermis, resulting in a higher or lower grade of edema. Even a slight grade of edema will exercise quite a marked influence on the process of cornification, resulting in a parakeratosis. The process of exudation of the serum from the papillary capillaries, with the passage of leukocytes and red blood cells, may be very rapid in its course. It channels into the epidermis, and may cause such a sudden strain on the intercellular bridges of the prickly cells that they are no longer able to withstand, and

they burst. However, suppose the edematous area is situated high up in the epidermis and that the area is covered only by a few layers of rapidly and incompletely cornified cells. Then when the pressure becomes too great the vesicle may break outward, containing fibrin, broken-down leukocytes and red blood cells. Such an exposed area is soon changed into a crust of coagulated serum, broken-down epithelium, nuclei, red cells and leukocytes. This is the height of the process. At this time we almost invariably find a secondary growth of Gram-positive skin cocci in the crust. There are also more or less changes in the deep corium. The vessels become dilated, the endothelial cells swollen, and an exudate of serum and polymorphonuclear cells is poured out into the surrounding tissues, resulting in a perivascular edema and inflammation. The perivascular edema may be so marked at this time that the tissues are entirely forced apart and broken up.

Again, suppose the irritation has continued for some time. Then an even more severe type of change around the vessels of the corium will be found. There is a heavy exudate of serum and leukocytes, the latter mostly small in type, with an occasional eosinophile and endothelial cell. The collagen fibers are swollen, forced apart, and stained poorly, while their nuclei are flattened from the pressure of serum in the tissues. The elastic fibers are also forced apart. The result of the copious supply of serum from the papillary vessels to the epidermis is that the cells receive better nutrition than normal, so they are continually bathed in serum. Instead of drying up they will continue to assimilate nutrition and to multiply. The result is the production of a thickened epidermis, showing an atypical process of cornification, parakeratosis. Moreover, examination shows us long interpapillary processes of epidermis made of large, healthy looking cells, showing numerous mitoses and apparently growing down into the corium as well as upward, acanthosis. This is the intermediate step between the acute and the chronic process. Crusts may or may not be present.

As the chronic stage begins to appear we find certain vascular changes that have a very important bearing. From the long-continued irritation we not only have the perivascular exudate already spoken of, but the vessel walls become thickened; and a few young fibroblasts are seen in the walls and in the surrounding tissues. This



thickening of the vessel walls tends to reduce the blood supply and, consequently, the edema. Once more, there is a return of the tissues to the normal from the decreased vascular supply.

Either the healing takes places through a process of chronic inflammation, as outlined above, or at the approach of spring the changeable, windy weather no longer irritates the susceptible parts. Even though the process be acute, by removing the causative factor the condition tends to subside from lessened blood supply, and thus a return to the normal is found.

From 1912 to 1939, a lapse of 27 years, the literature was silent about dermatitis hiemalis. Then Niles (19) broke the spell by a report on "Winter Eczema of the Arms." He believed that the eruption had not been previously described. The lesions consisted of round, dry, scaly red patches over the dorsal surfaces of the forearms. The patients described a varying symptomatology. The dermatitis appeared at the onset of cold weather, had been present previous winters, did not yield to therapy and disappeared spontaneously in the spring. The patients were of the better class and were the "clean types." The lesions suggested a fungus infection which could not be proven. A histological examination from a lesion on the arm showed parakeratosis, slight acanthosis, spongiosis in some areas, and edema of the upper cutis with enlarged blood vessels and a perivascular, round cell infiltrate. Eczema was the histological diagnosis. The account by Niles follows the original description by Corlett (16) of dermatitis hiemalis in the late stages. Two years later Carpenter (20) observed five cases which were diagnosed as "winter eczema." He described the lesions as scaly, circinate macules with a fine vesicular border so suggestive of a fungus infection that it was disturbing not to be able to prove this diagnosis. The upper and lower extremities were involved as well as the shoulders. These lesions are often very similar to the signs of the "herald patch" in pityriasis rosea. In Evansville, during and following severe cold spells, such lesions are seen frequently. They are found while conducting complete dermatological examinations. The face, neck, extremities and torso are the common sites. Patients refer to them as patches of "ringworms."

Reading Corlett's (16) description of dermatitis hiemalis brought out many of the charac-

teristics of nummular eczema. Reference to this dermatosis is not without some misgivings, but Gross (21) in 1941 mentioned that it is well known that nummular eczema appears or recurs in cold weather and clears up in summer. This has led to the synonym, "winter eczema." Warm weather cannot always be relied upon to produce involution. One of the criteria in patients with this disease is the presence of generalized asteatosis, xerosis with ichthyosiform or fine bran-like scaling over the extensor areas; and dryness, scaling and lichen pilaris are present over the elbows, knees and buttocks. A number of cases of nummular eczema have been followed over a period of several years. In the summer their skin is free of signs, but in winter the generalized xerodermic changes appear, followed by typical patches of nummular eczema on the hands. The signs fluctuate in severity, following the dew point curves in the atmosphere. In 1951 Gross (22) stated, "The yearly recurrences of nummular eczema with the onset of cold weather and the partial or complete remission in warm weather cannot escape our attention. I have seen extensive eruptions develop in natives of subtropical countries when they visited New York in winter, and conversely a trip to Florida may bring prompt relief to the Easterner suffering from nummular eczema."

Rowe (23) in a study of atopic dermatitis of the hands due to food allergy reported exacerbations in 32% of the patients during fall, winter or spring. A survey of overtreatment dermatitis of the hands disclosed that 77% of 84 cases noted the onset or recurrence of their hand eczema during the fall, winter or spring (24). Jordan and associates (25) from a study of 239 patients concluded that most of them who had had the first attack of dermatitis more than a year before coming under their observation, were either completely free from the condition or improved during the warm months. In the cases studied by Lane and co-workers (26) 40% of those who had had their dermatitis for more than one year thought their dermatitis was worse during cold months. These statistics are an encouragement to explore deeper the significance of cold weather in relation to hand eczema. Such a study is now in progress, but more important would be cooperative studies at different geographical locations. The eventual tally of data could reveal identical meteorological events associated with onset, remission and ex-

acerbation. Weather producing the eruptions in Chicago on a certain day, might one day later be producing the same in Evansville. The most recent reference was a report by Hill (27) on wool as a cause of eczema in children. There are many children affected with eczema who are nearly or entirely free from it in summer, but it recurs at the onset of cold weather and lasts through winter and spring. The distribution was the neck, ankles, wrists, backs of the hands, also the arms and legs. The extremities being chiefly affected is reminiscent of the distribution of pruritus hiemalis. The condition was designated, "winter eczema." It was caused by wool and is common in children. Reading the reports of cases described as pruritus hiemalis suggests that in some of them atopic dermatitis would have to be considered. Hill (27) stated, "although classical 'contact' and 'atopic' dermatitis have enough immunologic and clinical differences to warrant their separation in a classification of cases, elements of both are not uncommon."

#### Effects of Dry Air on Normal Skin

At dew point temperatures below 20° F., remarkable changes occur in the normal skin (1). A smooth, soft skin is changed into a rough and spiculated surface. A burning discomfort makes the person aware that desiccation is taking place. An adequate amount of moisture in the air—dew point temperature above 20° F.—is essential for maintaining the suppleness of the skin. An annual survey of chapping weather factors revealed the presence of high dew points followed by precipitous falls. These meteorological events bathed the skin in air with a high vapor pressure. The skin was even excessively moist, and suddenly this moisture was lost. The skin was now being bathed in exceedingly desiccating air. This apparently is the sequence of chapping. Attesting to the keenness of Hyde (7) and Payne (9) was their notation that it was not so much the severity of coldness as it was the rapid play of temperatures (rapid changes in the amount of moisture in the air).

The location of chapping was influenced by areas of skin most frequently wetted, namely the hands and the lips. Twenty-two per cent of patients with hand eczemas recalled that their hands were severely chapped when their dermatitis appeared (24). Meteorological events can cause the horny mantle on the hands to crumble,

fissure and exfoliate leaving erythematous, oozing surfaces. This is possibly a groundwork of changes for the onset of eczema. These same events can produce a recurrent nummular type of eczema on the legs. The dermatitis appears independent of the activities of the person. Water, soap, and detergents aggravate, but chapping weather factors initiate the onset of dermatitis.

#### Effects of Drying and Wetting

If the skin on the back of the hand is examined with a hand lens when it is soft and smooth, there is seen a cobweb-like film loosely adherent to the stratum corneum. The film is white. Desiccation is doubtless a part of the final stage of cornification. Immerse the hand in water for a few minutes; the white film is gone. Air exposure is followed by its reappearance; the time of which is related to the vapor pressure of the atmosphere. Dry air will cause it to appear more rapidly than moist air. In slight chapping the white film becomes more dense and moderate spiculation is noted; similar to the fine area of a food grater. Water removes this film, and there is noticed a tinge of residual redness to the skin. Moderate chapping is associated with a denser film and greater spiculation. Roughness of the skin is apparent, and the first symptoms are noticed. Water removes this film at the expense of more redness to the skin and more annoying symptoms. Severe chapping reveals a still more dense film and sharper spiculation, like the coarse part of a food grater. The skin is so rough that it meshes with the clothing. A burning sensation is almost continuous. Water, also, quickly removes this film, but the closeness of its depth to the cutis is evident by the appearance of bleeding points especially in the epithelial furrows. Apparently, desiccated cells of the stratum corneum are removed by water like the popping of corn in a popper. These observations suggest that the degree of moisture and dryness of the air is closely related to the soundness of the stratum corneum. Optimal environmental moisture favors an integrity commensurate with a maximal protective function.

Excessive environmental moisture in the summer allows too great a thickening of the horny mantle with the result that sweating disrupts it, producing so-called heat rashes involving the



feet, groin and hands, usually referred to as fungus infections.

A critically low environmental moisture can produce excessive peeling when the area is repeatedly wetted. This reduces the integrity to such a point that eczematizations may develop. An example of the sequelae from excessive environmental moisture are the feet in waterproof footwear which keeps them bathed in sweat. A result is the formation of all degrees of local and general, excessive pedal keratinizations. On removing the shoes, the horny layers are white, soggy and smell badly. After drying, typical keratodermic sandals may be demonstrated (28, 29).

### Relation of Injury to Susceptibility

In 1951 the authors (30) reported 18 cases with a history of an injury or dermatitis which had had overcare and overtreatment. The skin had had an excessive chemical exposure. These events preceded or were associated with the appearance of atopic dermatitis following the first cold spell in the fall. Critical temperatures and relative humidities were found to average below 52° F., and 52% relative humidity. Remissions and exacerbations followed the meteorological changes. In reviewing the subject of dermatitis hiemalis, it was surprising to find that Payne (9) and Corlett (10) noted cases with a previous history of dermatitis which involuted, but the following winter another dermatitis appeared having characteristics of atopic dermatitis. The following report of a case illustrates the sequence.

### Report of a Case

Case M. C., a white postmistress aged 32, was seen February 2, 1951. She showed a brightly erythematous and edematous dermatitis of the face, neck, upper torso and upper extremities. The neck and flexor surfaces of the arms wept huge drops of limpid serum. A month had been spent in a nearby hospital with little improvement. The family history disclosed nothing indicative. A maternal aunt had "dry tetter" of the feet. The patient was the cold type; she liked summer weather and was cold all winter. She hovered near the stove. She had had measles and mumps, and had a vaccination scar two centimeters in diameter. The present illness began the end of

December 1949. She recalled eating barbecues when her lips were chapped. Considerable burning was noted, and to relieve this she applied lip-ice. The burning lessened, but the next morning the circumoral skin was red. To this the lip-ice was likewise applied. The redness became worse and itching developed. Calmitol was applied freely. Within several hours, a dermatitis developed over the face and neck. As the dermatitis spread, more Calmitol was used, and soon the chest and arms were involved. Other home remedies were tried with little improvement. In the spring the eruption suddenly left. It reappeared with the same distribution November 30, 1950. Two days before, the weather had produced severe chapping. Immersion tests (30) disclosed a peripheral vascular sensitivity from cold to warm. This patient had been under observation almost a year. Using less soap, taking fewer baths and wearing more clothing has in a large measure solved her problem.

### Summary

This interpretation of the literature on the effects of cold weather on the skin has clarified certain points. The descriptions of pruritis hiemalis allow the inference that the disorder was a dermatitis from clothing, notably wool, conditioned by the desiccation of the epithelial mantle. If this be true, the affection has been wrongly classified as a neurosis. No support is found for the expressed concept that pruritus by itself induced the disease. Removal of wool and optimal air humidity, dramatically relieved the affection. Dermatitis hiemalis should have important consideration in the differential diagnosis of eczema of the hands. The subject of dermatoses from cold weather needs clarification and cooperative study for definition of the entities.

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# THE JOURNAL

OF THE

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## WORLD MEDICAL ASSOCIATION

INTERNATIONAL friendships and the experiences of doctors which grew out of World War II were the inspiration for the founding of the World Medical Association. During the war medical officers learned that many of the problems of medicine were world-wide in extent. They realized that international study and co-operation would lead to their more speedy solution.

The W.M.A. was formed as a voluntary organization in 1947 for the purpose of providing a means for improving the lot of the doctor and for improving the practice of medicine all over the world.

National medical association memberships form the basic structure of the W.M.A. The A.M.A. is one of the organization members. Individual memberships are afforded in the U. S. by the formation of a United States Committee, which is now accepting applications for membership from members of the A.M.A. An-

nual dues are \$10.00, which includes a subscription to the quarterly W.M.A. Bulletin.

The Bulletin is printed in three languages and contains the proceedings of the Association and reports of all its studies as well as items of world medical news.

The Association is proud to have adopted an International Code of Medical Ethics and a revised Hippocratic Oath known as the Declaration of Geneva. Both of these documents are modern in expression but reiterate the traditional ideals of the medical profession.

The activities of W.M.A. include a study of medical man power in the various countries. A survey is being made of medical education and postgraduate education in 26 countries. Cult practice, medical advertising, hospitals, and the world-wide distribution of drugs are being studied and will be reported on soon.

The World Medical Association (W.M.A.) is sometimes confused with the World Health Or-

ganization (W.H.O.) The World Health Organization is an official branch of the United Nations. It represents the governments of the world in the field of medicine. W.M.A. represents the *individual practicing physicians*. The two organizations cooperate with each other, but have no direct connection.

All members of the Indiana State Medical Association have been invited to become members of the W.M.A. Inquiries may be directed to 2 East 103rd St., New York 29, New York.

## JACOB T. OLIPHANT LIBRARY

**T**HE Indiana State Board of Health, of which Jacob T. Oliphant, M.D. is chairman, recently during a temporary absence of its chairman, named the library of the Board of Health, "The Jacob T. Oliphant Library."

Doctor Oliphant is a past-president of the Indiana State Medical Association and was formerly a member of the Editorial Board of *THE JOURNAL*. He has been a member of the State Board of Health since 1945. For many years before that he was local health officer. His many acts of service in the field of public health to the people of the State of Indiana, and to the people of his home community of Farmersburg are richly deserving of official recognition.

*THE JOURNAL* is happy to join with the members of the medical profession and with his many other friends in congratulating Doctor Oliphant on the occasion of this most appropriate honor.

## Editorial Notes

### Dr. S. M. Cotton Honored

S. M. Cotton, M.D. of Goldsmith was honored on August 24 by the celebration of his fiftieth year in practice. More than 3000 persons, many of whom Dr. Cotton had delivered, gathered to pay him tribute. He was presented with a plaque by the Tipton County Medical Society, and received a television set as a gift from the community.

## SOCIALIZED MEDICINE IN DISGUISE

**G**EORGE F. LULL, M.D., secretary and general manager of American Medical Association, recently wrote the following letter addressed to members of the medical profession:

August 18, 1952.

Dear Doctor:

In the eyes of American physicians today, the three initials "ILO" spell danger!

They stand for an international body which eventually may change the whole concept of medical practice throughout the world.

ILO means International Labor Organization, an affiliated agency of the United Nations. It comprises some 60-odd active member-governments. Its policy-making body is the International Labor Conference, which meets annually, usually in Geneva where the staff maintains permanent headquarters.

The last ILO conference was held in June and since then more and more evidence is accumulating that the drive for socialized medicine has shifted from the domestic scene to the international scene.

The ILO is one of the oldest and most important of the maze of international organizations functioning today, and the American Medical Association has been watching its work for years. It now is felt that the time has come to acquaint American physicians with the facts and let them know that, while the issue of socialized medicine is quiescent so far as the public and Congress are concerned, there is danger of having it walk through a back door under the guise of an international treaty.

Ratification of the ILO's newest Convention (Treaty) on Minimum Standards of Social Security by a two-thirds vote by only the Senate would establish "socialized medicine" irrespective of the wishes of the majority of the members of Congress and the public to the contrary. The medical care section of the convention stipulates in part that a country ratifying must provide a system of compulsory health insurance. Lacking this, it has two alternatives: 1. Private, voluntary health insurance administered by public authorities under established regulation, or 2. Private voluntary health insurance administered by insurance companies under government supervision.

The A.M.A. Journal lately has published considerable material on the ILO and its health objectives, and more articles are scheduled to appear in the very near future. This is "must" reading for every physician.

For back reading, physicians are invited to turn to the Organization Section of the Journal, May 31, 1952; to the excellent statement of A.M.A. President Louis H. Bauer on page 869 of the June 28 issue of the Journal; to Capitol Clinic Vol. 3, No. 26, July 1, 1952,



and to the Washington News Section of the Journal, July 12, 1952.

Here is part of another editorial—"Socialized Medicine—the ILO Way"—which will appear in the Journal, August 23:

Although the battle against the proponents of political medicine has been won, at least temporarily, in our state legislatures and in the Congress, we are in danger of losing the war through an international approach.

The same forces which unsuccessfully attempted to socialize the medical profession through legislation are finding it much easier to work through the United Nations and the International Labor Organization. In our enthusiasm to espouse such principles as "fundamental human rights," "social progress," and "international peace and security," we have aided and abetted the activities of these forces. Through the wholesale approval of treaties, conventions, and executive agreements, our international representatives have placed not only American medicine, but our national sovereignty and our Constitution in jeopardy.

Socialism by treaty is now a greater threat than socialism by domestic legislation, principally because the possibility of political and economic regimentation from an external source is not widely recognized. The public is unaware of the dangers inherent in the treaty-

making power, because during the first 150 years of our Republic, treaties concerned only the relationship between the United States and other sovereign states. Their attempted use to define the relationship between American citizens and their own government is a recent development—a development, however, which can result in the subtle realization of the socialist's dream of cradle-to-the-grave security.

A recent covenant, entitled "Minimum Standards of Social Security," approved by the International Labor Organization in Geneva in June, 1952, envisions government benefits in nine fields of social security—medical care, sickness benefits, unemployment benefits, old age pensions, employment injury benefits, family allowances, maternity benefits, invalidity benefits, and survivors' benefits. While the medical benefits in the covenant are carefully distributed through the document, considered together they constitute "socialized medicine."

It is time, therefore, that as a nation, and as a profession, we stop and analyze the results and potentials of our international actions. It is the duty of every physician to acquaint himself with the history, the purpose, and the plans of the United Nations, and the International Labor Organization.

In addition, the American Medical Association and its component societies must wage the same vigorous campaign against socialism by treaty that it is now conducting against socialism made-in-America.

*Detach, fill in bottom line, and display in office or on office door*

## Doctor Is Out

He is attending the 103rd Annual Session of the Indiana State Medical Association at Indianapolis, where he is hearing scientific lectures by the nation's leading scientists and viewing the latest medical and surgical techniques and equipment by movies and exhibits.

Doctor will be in his office.....



## President's Page



Dear Members:

As we head now for the stretch and toward the Annual Meeting which will terminate my tenure as President I thank each and every one of you for the privilege and honor of serving this grand organization.

It has been my privilege to visit all parts of the state in the past two years and I have been greatly pleased at the most courteous reception.

I wish to thank the members of the various committees for their splendid cooperation and unselfish devotion to tasks that sometimes were not too pleasant.

The program for the annual convention is completed. We are returning to section meetings again and the chairman of each section has prepared a bang-up program. In addition, the general committee has arranged a program of great interest to everyone.

There will be a change in the method of registration which will be at the entrance to the exhibits and no one will be admitted without a badge.

In order to prevent delay and overlapping with the scientific sessions the House of Delegates will meet at the Atheneum for breakfast at 7:30 a.m. Tuesday, October 28.

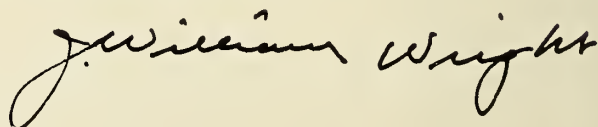
All meetings will start promptly as scheduled as ample time has been allotted to visit exhibits and for other recreational activities.

On Wednesday evening no one will be seated except during intermission.

The annual banquet must start promptly as scheduled due to the problem of limited time from the personnel angle.

Again thanking you and trusting you will make this a gala affair and also urging you to accord Dr. Paul Crimm the same magnificent support you have given me, I am,

Sincerely and fraternally yours,





# Medical Panorama *by the* ASSOCIATE EDITOR

## A "PLUG" FOR THE PROFESSION

At the Marquette Medical Alumni Spring Clinics held in Milwaukee March 29, 1952, Dr. Francis D. Murphy gave an address on "Scientific Advances, Specialization, and Public Relations", which address has been printed in condensed form in *The Wisconsin Medical Journal* for July, 1952. We herewith extract a bit or two from the "condensation":

Surveys of public opinion on several occasions have shown that the majority of patients have full confidence and deep regard for their own individual physician, but, on the other hand, have little confidence or little or no regard for the profession as a whole. The unpopularity of the medical profession makes the physician bear the brunt of complaints about the high cost of sickness. This is not justified, for it must be remembered that his fee is only part of the total expense. Various cost of living analyses indicate that doctors' fees and physicians' incomes have not gone up in proportion to the costs of hospitalization, medicines, special diagnostic services, and sick room supplies, or in fact to the price indexes generally.

Another explanation for the loosening of the bonds between the doctor and the patient is that more attention is being devoted to the disease itself, to methods of diagnosis, and to agents of treatment than to the individual himself. Formerly, patients were studied and treated more personally because the physician had to rely on inspection, palpation, percussion, auscultation, and careful interrogation and observation of the patient. Now we must admit that diagnostic machinery and impersonal devices have begun to take too prominent a place in the management of patients. This need not, and should not, occur. The use of any special laboratory technic begins at the bedside. I can easily understand that the patient as an individual seems to be taking a place of secondary importance to his disease. I should like to emphasize that I am not placing less emphasis upon the disease, its diagnosis, and treatment, but I wish to emphasize there is also a need for more careful attention to the patient as an individual. Perhaps teachers have been lax in emphasizing the importance of this factor. I am sure that interns, residents, and staff members, as well as practicing physicians, would take heed of such lessons if they came from the prominent educational centers and medical schools.

To blame the public and complain about their spending a great deal of money for other things and begrudgingly spending money for medical service does not

answer the question. To understand the public's attitude and to try earnestly and honestly to correct the problem is the only way to meet the situation.

As to specialists, Dr. Murphy states: "Mere certification is not an end in itself, and the young practitioner who seeks it only with thoughts of an easier life and bigger fees is in need of mature counselling." He elaborates further:

"It is my belief that the chief motive of most specialists is the comfort and consolation obtained from the more skillful management of patients, and the gratification that comes to nearly all physicians from the feeling of greater achievement in their work."

This seems to us a discerning perception of that viewpoint which is essential to any follower of Aesculapius who desires insight into his profession and its deepest satisfactions,—be he general practitioner or specialist.

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## AMA Prepares New Health Exhibit

Designed for lay audiences, a new portable exhibit entitled "Health-1952" is now available from the AMA's Bureau of Exhibits for state and county medical societies. The exhibit presents an over-all picture of health conditions in the United States at the present time. The first panel, containing a large, colored modern adaptation of Sir Luke Fildes' painting, "The Doctor," emphasizes improved health conditions in the country today—showing that life expectancy has increased, tuberculosis, diphtheria and pneumonia deaths have skidded to an all-time low, mothers and babies have a much greater chance of surviving today. The second theme shows that Americans require less working time to pay for medical care today as compared with 15 years ago. Finally, the exhibit points out that today there is an easier way to pay for medical care—through voluntary health insurance.

The Bureau plans to revise and bring the exhibit up to date each year. The only cost involved to medical societies will be the shipping charges both ways.

## JEANNE S. GROVER BECOMES JOURNAL SECRETARY

**M**RS. JEANNE S. GROVER, Indianapolis, has assumed the post of editorial secretary of *THE JOURNAL* of the Indiana State Medical Association. She replaces Mrs. Isabella Rowilson who resigned after many years' service.

Mrs. Rowilson joined *THE JOURNAL* staff on a part time basis in 1935 and became a full time employee in 1940. After spending several years in Dallas, she returned to the staff in 1945 and had served as editorial secretary since. She has entered the general insurance field.

Mrs. Grover, a native of Wabash, served as city editor of the Wabash Plain Dealer and

Times Star, a morning and evening daily newspaper, for more than 10 years, was a reporter on the Fort Wayne News-Sentinel and for several years did free lance writing and publicity in Boston, Massachusetts. After resigning her Wabash newspaper position, Mrs. Grover was with the public relations department of General Tire & Rubber Company until 1950. During the 1951 regular and special sessions of the Indiana General Assembly she served as the assistant Secretary of the Senate. Before coming to the *Journal* on August 1, Mrs. Grover had been office manager and handled publicity for the Indiana Taft headquarters.

## The Fourth Estate Looks At Medicine

**This section of *THE JOURNAL* is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.**

### A THREAT TO MEDICINE

Dr. Joel T. Boone, medical director of the veterans administration, addressed a threat to the civilian profession of medicine that if there is not continuing coöperation with government medical projects it may mean the end of civilian medicine. He said that, in the absence of a relationship satisfactory to the bureaucrats, the government "would have to take over."

The Truman administration has for a long time talked in a large way of installing a system of compulsory health insurance and of resorting to various devices to equalize medical attention between those more able to pay and those less able to pay. It has invariably insisted that it had no design for socializing medicine.

These declarations of innocent intent must be measured against Dr. Boone's clear threat and his peculiarly intimate relationship with the administration and the White House. As a rear admiral in the navy, he served as the White House physician during Republican administrations of the '20s, then returned to active duty with the navy. Last year he was appointed to his position with the veterans administration. Altho listing himself as a Republican, he has been associated during his career of 38 years of active practice with state medicine, and he brings to bear a viewpoint sympathetic to government direction rather than to the freedom of the private practitioner.

The sense of the phrase to "take over" is well understood. It means that the government will assume command of the practice of medicine and of all those who engage in it. It means that government will decree the kind of medical attention given, who is to receive it, what the costs shall be, and how they are to be met. If the government were to "take over," the government would operate all hospitals, all medical schools, all research in medicine, all nursing, and probably all such related activities as dentistry, etc.

This socialist organization of medicine would be bound to rest upon compulsion. Once one major profession fell to the state, what would stop all others from going the same way? We should have a nationalized legal service, a nationalized press, and all of the rest of it, until finally no area of freedom survived and the Bill of Rights would have become a dead letter.

Perhaps the servitude of the professions might have a temporary attraction for the masses who had been led to believe they would get something more for nothing—or for what looked like nothing. But this attitude would quickly prove to be a delusion. The servitude of one group of free citizens soon becomes the servitude of all. The philosophy that the government can "take over" is the philosophy of total dictatorship.

—Chicago Tribune



# **ONE HUNDRED AND THIRD**

**Annual Session**

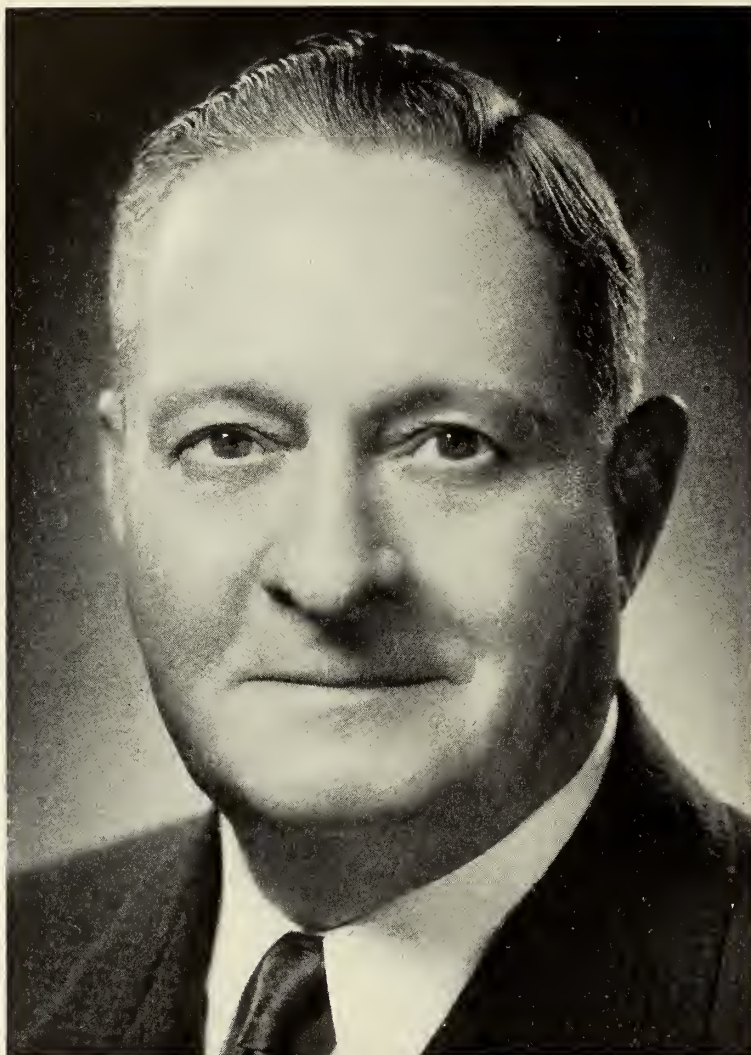
**INDIANA STATE MEDICAL ASSOCIATION**

**Indianapolis, Indiana**

**October 28, 29 and 30, 1952**

**Headquarters—Murat Temple**

***Complete Program on following pages***



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Indianapolis

PRESIDENT

INDIANA STATE MEDICAL ASSOCIATION

1951-52

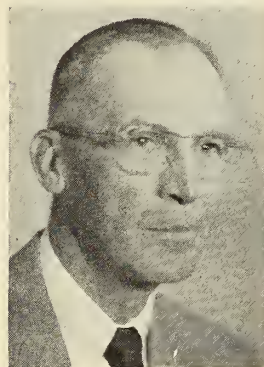


## INDIANA STATE MEDICAL ASSOCIATION

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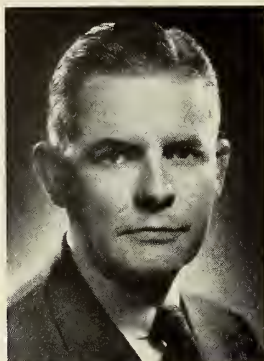
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Crawfordsville



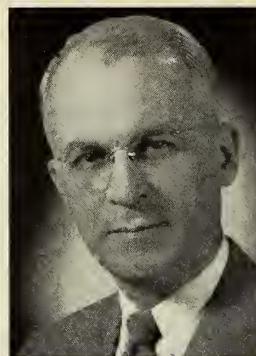
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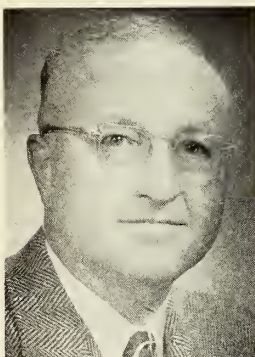
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Editor Emeritus  
THE JOURNAL  
Hammond



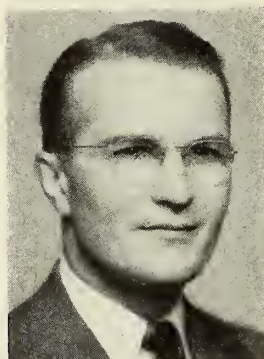
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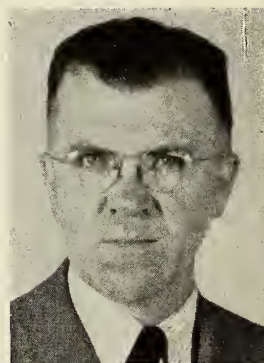
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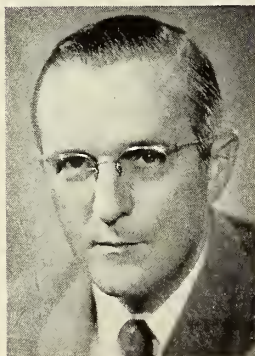
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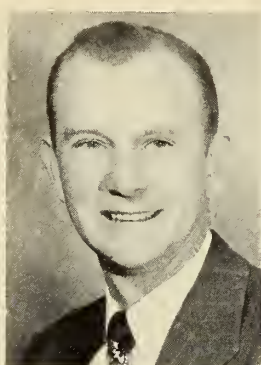


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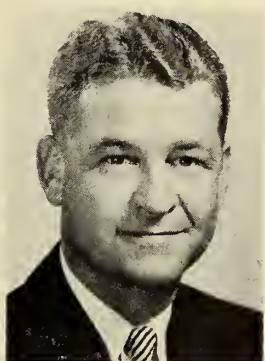
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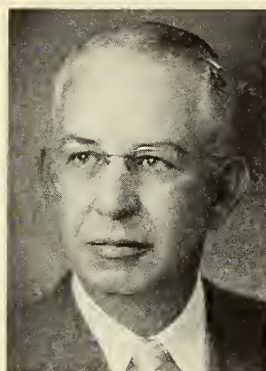
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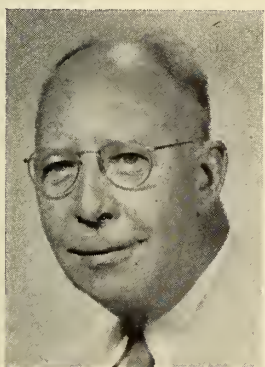
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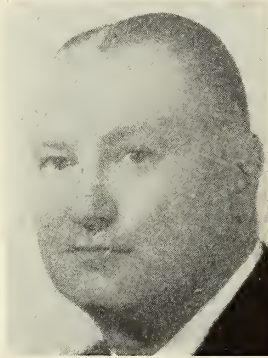
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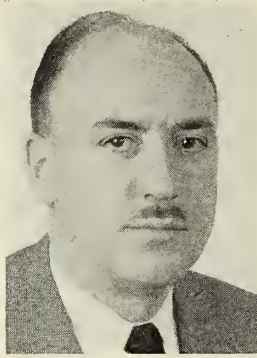
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C. O. McCORMICK  
Chairman  
Section on Obstetrics  
and Gynecology  
Indianapolis



THOMAS C. HALLER  
Secretary  
Section on Surgery  
Crawfordsville



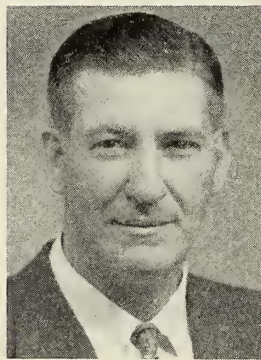
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Section on Medicine  
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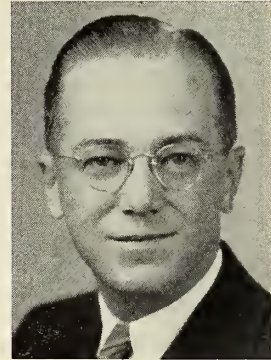
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Section on Obstetrics  
and Gynecology  
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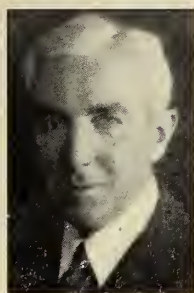
The schedule of courses and the order

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Courses are on page 1032 of this issue.



## Meet the Speakers



Rock

**John Rock, M.D.**, Brookline, Massachusetts, clinical professor of gynecology, Harvard Medical School, Boston. Born in 1890; M.D., Harvard Medical School, 1918; certified by American Board of Obstetricians and Gynecologists. Member American Gynecological Society; American College of Surgeons, New England Surgical Society and American Psychosomatic Society. Contributor to many scientific journals and author of articles and books.



Johnson

**Robert Lee Johnson, M.D.**, Bluffton. Born North Carolina, 1892; M.D., Rush Medical College of University of Chicago, 1926. Former assistant professor physiology, University of Cincinnati School of Medicine; now engaged practice psychosomatic medicine. Member American Gastrosopic Society; American Gastroenterological Association; American Association for Advancement of Science; American College of Chest Physicians.

**William B. Tucker, M.D.**, Minneapolis, professor of medicine, University of Minnesota Medical School and chief of tuberculosis service, Veterans Administration Hospital, Minneapolis, since 1947. Born in Peitaiho, North China in 1905; M.D., University of Chicago School of Medicine, 1934. Former associate professor of medicine, University of Chicago School of Medicine. Chairman, Committee on Plans, Conference on Chemotherapy of Tuberculosis of Veterans Administration since 1947; chairman, Committee on Therapy, American Trudeau Society, Medical Section of National Tuberculosis Association 1949 to 1952; Member editorial board of American Review of Tuberculosis, 1950-53; member of Council, American Trudeau Society, 1951-54 and of its executive committee, 1952-53.



Tucker

**Richard R. Owens, M.D.**, Muncie. Born in 1910; 1938 graduate of Harvard University Medical School. Certified by American Board of Internal Medicine; in private practice, specializing in internal medicine.

**Richard N. Kent, M.D.**, Fort Wayne. Consultant in medicine, Veterans Administration hospital, Fort Wayne; specialist in internal medicine. Born in Fort Wayne July 1, 1911; M.D., Northwestern University Medical School, 1937; former instructor in neurology, Methodist Hospital School of Nursing, Fort Wayne. Diplomate American Board of Internal Medicine; Fellow American College of Physicians; M. S. in Medicine, Mayo Foundation, University of Minnesota, 1946.



Kent



Thomas

**George J. Thomas, M.D.**, Pittsburgh, associate professor of surgery and chairman of the section on anesthesiology at the University of Pittsburgh School of Medicine. Born in Pittsburgh, 1896; M.D., Ohio State University College of Medicine, 1923. Consultant, Veterans Administration Hospital, Pittsburgh; director of department of anesthesiology St. Francis and Medical Center Hospitals, Pittsburgh; chairman, committee on hospital hazards and standardizations of anesthesia and resuscitating equipment of the American Society of Anesthesiologists.



Chappel

**Alfred T. Chappell, M.D.**, with cardiology section of the Medical Service, U. S. Army Hospital, Camp Atterbury, Indiana since 1951. Born Fremont, Nebraska, 1923; M.D., Indiana University School of Medicine, 1948. Internship and partial residency in internal medicine at Henry Ford Hospital, Detroit.



Irwin

**Glenn W. Irwin, M.D.**, Indianapolis, assistant professor of medicine, Indiana University School of Medicine. Born in Roachdale, 1920; M.D., Indiana University School of Medicine, 1944.



Davis

**Joseph B. Davis, M.D.**, Marion, staff surgeon, Davis Clinic and Marion General Hospital, Marion; consultant Veterans Administration Hospital, Marion. Born in Marion, 1917; M.D., Indiana University School of Medicine, 1942. Diplomate American Board of Surgery; fellow American College of Surgeons.

**Paul J. Fouts, M.D.**, chief of medicine service, General Hospital, Indianapolis, and assistant professor of medicine, Indiana University School of Medicine; consultant in hematology; specialist in internal medicine. Born in Indiana, 1905; M.D., Indiana University School of Medicine, 1929. Member American Board of Internal Medicine; Central Society for Clinical Research and American Society for Clinical Investigation.



Fouts

**Mell B. Welborn, M.D.**, Evansville, chief of Surgical Service of Welborn Memorial Baptist Hospital. Born Pendleton, South Carolina, 1907; received M.D., Emory University, 1931. Fellow of American College of Surgeons and Diplomate of American Board of Surgery.



Welborn



Wilmore

**Ralph C. Wilmore, M.D.**, Indianapolis, assistant professor of medicine, Indiana University School of Medicine. Born in Winchester, 1916; M.D., Indiana University School of Medicine, 1939. Specializes in internal medicine.



Ryan

**William J. Ryan, M.D.**, Columbus. Born in Akron, Ohio in 1907; M.D., Western Reserve School of Medicine, Cleveland, 1937; graduate in surgery School of Medicine, University of Pennsylvania, 1951; now engaged in practice of general surgery. Member Part I of American Board of Surgeons; associate in International College of Surgeons.

**J. S. Battersby, M.D.**, Indianapolis, assistant professor of surgery Indiana University School of Medicine. Born Lake County, Indiana, 1911; M.D., Indiana University School of Medicine, 1939. Fellow American College of Surgeons; diplomate American Board of Surgery.



Battersby

**Frank M. Scott, M.D.**, South Bend. Born in Clinton, Indiana, 1912; M.D., Indiana University School of Medicine, 1937. Diplomate of American Board of Surgery; fellow of American College of Surgeons.





Eicher

sociation and American Academy of Orthopedic Surgeons.

**Palmer O. Eicher, M.D.**, Indianapolis, assistant in Department of Orthopedics, Indiana University School of Medicine; associate staff, Indianapolis General Hospital. Born Berne, Indiana, 1904; M.D., Indiana University School of Medicine, 1932. Engages in private practice, specializing in orthopedics. Member American Rheumatism As-



Van Buskirk

dianapolis Ophthalmological and Otolaryngological Society.

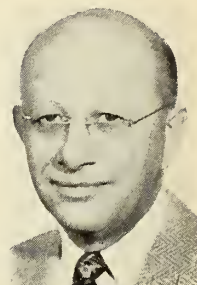
**Edmund L. Van Buskirk, M.D.**, West Lafayette. Consultant in ophthalmology, Arnett Clinic, Lafayette. Born in Fort Wayne, 1907; M.D., Indiana University School of Medicine, 1933. Member American Board of Ophthalmology; fellow, American Academy of Ophthalmology and Otolaryngology; fellow, American College of Surgeons; member, In-

**Ralph J. McQuiston, M.D.**, assistant professor of otolaryngology, Indiana University School of Medicine; consultant in otolaryngology Indiana University Medical Center and General Hospital, Indianapolis. Born in Franklin, Indiana, 1905; M.D., Indiana University School of Medicine, 1932. Member American Board of Otolaryngology; American Academy of Ophthalmology and Otolaryngology; American Laryngological, Rhinological and Otolological Society, American Otolological Society and the American College of Surgeons.



McQuiston

**Maurice V. Kahler, M.D.**, Indianapolis. Born Star City, 1894; M.D., Indiana University School of Medicine, 1919. Past president Indiana Academy of General Practice; member of Council of Indianapolis Medical Society; member of committee on Physician-Hospital Relationship; member Committee of Indiana Hospital Administrators, Nurses and Physicians and chairman of Permanent Study Committee on Medical Care Insurance.

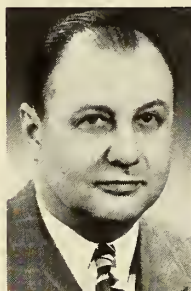


Kahler



Rudolph

**Carl Joseph Rudolph, M.D.**, South Bend. Born in Indiana, 1905; M.D., Indiana School of Medicine, 1931. Former assistant instructor New York Eye and Ear Infirmary; now in private practice, specializing in eye surgery. Member American College of Surgeons, American Board of Ophthalmology, associate examiner for Board of Ophthalmology.



Bibler

**Lester D. Bibler, M.D.**, Indianapolis. Born Findlay, Ohio, 1902; M.D., Indiana University School of Medicine, 1925. Vice president American Academy of General Practice. Instructor in outpatient medicine, General Hospital, Indianapolis.

**Kenneth L. Craft, M.D.**, assistant professor of otolaryngology, Indiana University School of Medicine. Born in Indianapolis, 1890; M.D., Indiana University School of Medicine, 1916. Member American Board of Otolaryngology; American Academy of Ophthalmology and Otolaryngology; American College of Allergists.



Craft

**Walter L. Portteus, M.D.**, Franklin. Born in Indianapolis, 1900; M.D. from Indiana University School of Medicine, 1924. Engaged in general practice of medicine; member executive committee Indiana State Medical Association.



Portteus



Dickson

**Dale Donald Dickson, M.D.**, Greensburg. Born in 1907; M.D., Indiana University School of Medicine, 1932. In private practice of general medicine.



Smith

**David L. Smith, M.D.**, Indianapolis, associate professor of obstetrics and gynecology, Indiana University School of Medicine. Born in Indianapolis, 1896; M.D., Indiana University School of Medicine, 1922. Member Central Association of Obstetricians and Gynecologists.

**Wemple Dodds, M.D.**, Crawfordsville, who is chairman of the Council of the Indiana State Medical Association, was born in Anna, Illinois in 1901; M.D., Indiana University School of Medicine, 1928. Consultant Culver Hospital, Crawfordsville; in private practice, specializing in radiology and pathology. Former assistant professor of bacteriology and pathology, Indiana University School of Medicine; diplomate American Board of Radiology; member American Society of Clinical Pathologists, Radiological Society of America, Inc., and American College of Radiology.



Dodds

**Mahlon F. Miller, M.D.**, Fort Wayne, specialist in obstetrics and gynecology; instructor in obstetrics Schools of Nursing, Lutheran and Methodist Hospitals, Fort Wayne. Born in Defiance, Ohio, 1906; M.D., Indiana University School of Medicine, 1935. Diplomate American Board of Obstetrics and Gynecology; fellow American College of Surgeons, member Academy of Obstetrics and Gynecology and Indianapolis Obstetrical and Gynecological Society.



Miller



C. O. McCormick

**Charles O. McCormick, M.D.**, Indianapolis, professor of obstetrics, Indiana University School of Medicine; engages in private practice in obstetrics and gynecology. Born in Tippecanoe county, Indiana, 1886; M.D., Harvard Medical School, 1913. Diplomate American Board of Obstetrics and Gynecology; member American College of Surgeons; member

American Association of Obstetricians, Gynecologists and Abdominal Surgeons and honorary member International College of Anesthetists. Author of textbook on obstetrics.



Gustafson

**Gerald W. Gustafson, M.D.**, Indianapolis. Born in Chesterton, 1899; M.D., Northwestern University Medical School, 1925. Professor of obstetrics and gynecology, Indiana University School of Medicine; consultant in obstetrics and gynecology, General Hospital, St. Vincent's, Methodist and Coleman Hospitals, Indianapolis. Fellow of American Association of Obstetricians, Gynecologists and Abdominal Surgeons; fellow, American College of Surgeons; fellow, Central Association of Obstetricians and Gynecologists; fellow, American Academy of Obstetrics and Gynecology.

**Silas H. Starr, M.D.**, Louisville, clinical professor of obstetrics and gynecology, University of Louisville Medical School; specializes in obstetrics and gynecology in private practice. Born Louisville, 1901; M.D., University of Louisville, 1924.



Starr

**Pierce MacKenzie, M.D.**, Evansville, consultant in obstetrics and gynecology at Deaconess, St. Mary's and Welborn Baptist hospitals, Evansville. Born in Elwood in 1893; M.D., Rush Medical College, 1919; specialist in obstetrics and gynecology. Member Central Association of Obstetricians and Gynecologists and American College of Surgeons.





Gardiner

**Sprague H. Gardiner, M.D.**, Indianapolis, assistant professor of obstetrics and gynecology, and member of the staff of Indiana University School of Medicine since 1946. Born 1910; M. D. University of Michigan Medical School, 1934; interned and residency, University of Michigan hospitals. Former instructor in obstetrics and gynecology, Johns

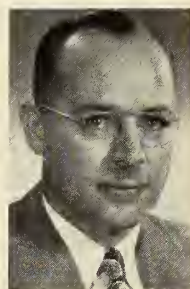
Hopkins University School of Medicine; served with army medical corps from 1942 to 1946. Diplomate American Board Obstetrics and Gynecology and American Board Psychiatry and Neurology; member Central Association of Obstetricians and Gynecologists and American Psychiatric Association.



Huber

**Carl P. Huber, M.D.**, Indianapolis, professor and chairman department of obstetrics and gynecology, Indiana University School of Medicine. Born 1903 in Ann Arbor, Michigan; M.D., University of Michigan, 1928. President of American Academy of Obstetrics and Gynecology; member American Board of Obstetrics and Gynecology; American Gynecological Society and Central Association of Obstetricians and Gynecologists.

**Frank W. Peyton, M.D.**, chief of staff St. Elizabeth Hospital, Lafayette. Born Colorado in 1909; M.D., University of Colorado, 1934; taught as director of obstetrics and gynecology residency program, St. Elizabeth Hospital, Lafayette; now consultant and chief of staff in Obstetrics and Gynecology Department, St. Elizabeth Hospital. Member American Academy of Obstetricians and Gynecologists (vice chairman of Indiana); member Central Association of Obstetricians and Gynecologists; diplomate American Board of Obstetrics and Gynecology; member active staff, Home Hospital, Lafayette.



Peyton

**Alex W. Cavins, M.D.**, who is associate editor of *THE JOURNAL*, was born in Terre Haute in 1900; received M.D. Johns Hopkins 1925; now gynecologist, Terre Haute; diplomate American Board of Obstetrics and Gynecology; fellow of American College of Surgeons; member American Academy of Obstetricians and Gynecologists and Indianapolis Obstetrical and Gynecological Society.



Cavins



Bickel

**David A. Bickel, M.D.**, South Bend, chief of staff Memorial Hospital, South Bend; consultant Memorial and St. Joseph Hospitals. Born in Indiana, 1893; M.D., Indiana University School of Medicine, 1921. Member American Board of Obstetrics and Gynecology; Central Association of Obstetricians and Gynecologists and American College of Surgeons.

Member editorial board *THE JOURNAL* of the Indiana State Medical Association.



Emerson

**Haven Emerson, M.D.**, New York, member of the Board of Health of City of New York and emeritus professor of public health practice, Columbia University; consultant to American Public Health Association. Born in New York City, 1874; M.D., College of Physicians and Surgeons, Columbia University, 1899. Recipient of Distinguished Service Medal from the United States; Legion of Honor, France; Sedgwick Memorial medal and Lasker Award in preventive medicine and public health. Director health and hospital surveys in many cities of U. S., also Athens, Greece; served as officer, Medical Corps, U. S. Army, duty with A. E. F., 1918-19; author and editor of many technical articles.



Francis

**Thomas Francis, Jr., M.D.**, Ann Arbor, Michigan, professor and chairman of department of epidemiology, School of Public Health, University of Michigan; professor of epidemiology, department of pediatrics and communicable diseases, University of Michigan Medical School. Recipient, Lasker Award, American Public Health Association, 1947;

member National Academy of Sciences. Since 1941, director of Commission on Influenza, Armed Forces Epidemiological Board and consultant to the Secretary of War; president American Society for Clinical Investigation, 1945-46; president, Society of American Bacteriologists, 1947; president, American Association of Immunologists, 1949-50.



Sborov

**Victor M. Sborov, M.D.**, Washington, D. C., chief of department of hepatic and metabolic diseases, Army Medical Service Graduate School, Army Medical Center, Washington, D. C., and instructor in medicine, Georgetown University Medical School. Born in Minneapolis, 1919; M.D., University of Minnesota Medical School, 1944.

**Paul William Schafer, M.D.**, professor of surgery and chairman of the department at the University of Kansas School of Medicine, consultant in thoracic surgery, Veterans Administration Hospitals, Kansas City, Kansas. Born in Ohio in 1915; M.D., Ohio State University 1939.

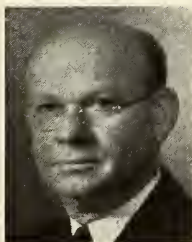


Schafer

**Arthur J. Patek, Jr., M.D.**, New York, assistant clinical professor of medicine, Columbia University College of Physicians and Surgeons; consultant in internal medicine, specializing in diseases of the liver. Born in 1904 in Milwaukee; M.D., Harvard Medical School, 1930; research in hematology 1932-36 at Thorndike Memorial Laboratory, Boston City Hospital.



Patek



Wiseman

**Bruce K. Wiseman, M.D.**, professor and chairman, department of medicine, Ohio State University College of Medicine; chief of medicine, University and St. Francis' Hospitals, Columbus, Ohio; specializes in hematology and internal medicine. Born in South Bend, 1897; M.D., Indiana University School of Medicine, 1929. Associate editor, American Medical Association Archives of Internal Medicine.

tor, American Medical Association Archives of Internal Medicine.



Zollinger

**Robert M. Zollinger, M.D.**, professor and chairman, Department of Surgery, Ohio State University and chief of surgical service, teaching hospitals, Ohio State University. Born Millersport, Ohio, 1903; M.D., Ohio State University, 1927. Formerly assistant professor at Harvard University and surgeon, Peter Bent Brigham Hospital, Boston.





Ritchey

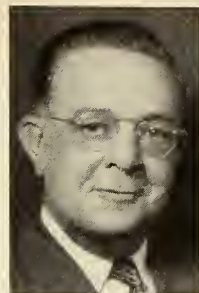
**James O. Ritchey, M.D.**, Indianapolis, chairman of the department of medicine at the Indiana University School of Medicine. Born in Indiana in 1891; M. D., Indiana University School of Medicine, 1918. In private practice, specializing in internal medicine. Member American College of Physicians.

**R. Morton Bolman, M.D.**, Fort Wayne, director St. Joseph Hospital Postgraduate Ampitheatre, educational director St. Joseph Hospital School of Nursing. Born Fort Wayne, 1915; M.D., Northwestern University Medical School, 1941; engages in private practice in general and thoracic surgery. Diplomate National Board of Medical Examiners; diplomate American Board of Surgery; fellow of American College of Surgeons. Now chief surgeon, St. Joseph Hospital, Fort Wayne; formerly chief of surgical division of 108th U. S. Hospital, Paris, 1944-45.



Bolman

**Edward J. McCormick, M.D.**, Toledo, president-elect of the American Medical Association. Born in Alger, Michigan, 1891; M.D., St. Louis University School of Medicine, 1915. Served as officer Medical Corps, U. S. Army, attached to British Expeditionary forces, 1917-19; member Walter Reed Hospital staff, 1919-22. Became member staff St. Vincent's Hospital, Toledo, 1922; member executive committee and chairman advisory board, St. Vincent's; director of surgery, member executive committee, Maumee Valley Hospital, Toledo since 1935. Past president Toledo and Lucas County Academy of Medicine, Ohio State Medical Association and Toledo Board of Health; U. S. delegate to Third World Health Organization, Geneva, Switzerland, 1950; member Medical Mission to Japan, 1949. Fellow American Medical Association, the American College of Surgeons and the International College of Surgeons; diplomate American Board of Surgery; member American Association for Advancement of Science, Tri-State Medical Association, Northwestern Ohio Medical Association, American Association of Railway Surgeons and World Medical Association.



E. J. McCormick



# Official Program

One Hundred and Third Annual Session

INDIANA STATE MEDICAL ASSOCIATION

Murat Temple

Indianapolis, Indiana

October 28, 29, 30, 1952

## Monday, October 27, 1952

- 3:00 p.m. Executive Committee meeting, Columbia Club.  
6:30 p.m. Council meeting, Columbia Club (Dinner meeting.)

## Tuesday, October 28, 1952

### Morning

- 7:30 a.m. Meeting of House of Delegates, Kellersaal, Athenaeum. (Breakfast meeting.) Business meeting in Little Auditorium, Athenaeum. Invocation, Most Reverend Paul C. Schulte, Archbishop of Indianapolis.  
7:30 a.m. Breakfast meeting of Committee on Industrial Health, Club Room J, Hotel Lincoln.  
8:00 a.m. Registration starts, lounge room, Murat Temple.  
Purchase your banquet tickets at the registration desk.  
8:30 a.m. Opening of technical and scientific exhibits, lounge room, Murat Temple.  
10:00 a.m. Annual golf tournament. Medal play, based on low gross and handicap. Meridian Hills Country Club.  
10:00 a.m. Annual trap shoot, Indiana Gun Club.  
10:00 a.m. Editorial Board meeting, Officers' Room, Murat Temple.  
11:00 a.m. Instructional courses, Murat Temple.

### Noon

- 12:00 m. Luncheon meeting of Indiana Association of Pathologists, Ladies Parlors, Athenaeum.  
12:00 m. Luncheon meeting of Committee on Mental Health, rear of Palm Room, Athenaeum.  
12:00 m. Phi Chi luncheon, Veterans Room, Athenaeum.

### Afternoon

- 1 to 5 p.m. Instructional courses, Murat Temple.  
5:30 p.m. Exhibits close.

### Evening

- 6:00 p.m. Reception and annual dinner meeting for women physicians, Indianapolis Athletic Club. (Dinner at 6:30.)

- 6:00 p.m. Buffet supper, smoker and stag party, Dining Room, Murat Temple.  
6:00 p.m. Dinner meeting, Class of 1906 of Indiana Medical College, Fraternity Room, Athenaeum.  
7:00 p.m. Dinner meeting of Indianapolis Obstetrical and Gynecological Society. Indianapolis Athletic Club.  
Speaker: JOHN ROCK, M.D., Boston.  
Subject: "*Human Conception.*"  
8:15 p.m. Entertainment for physicians, their wives, and guests, Murat Theater.  
Speaker: COUNTESS MARIA PULASKI.  
Subject: "*My Life as a Spy.*"

## Wednesday, October 29, 1952

### Morning

- 8:00 a.m. Registration continues, lounge room, Murat Temple. Purchase your banquet tickets at the registration desk.  
8:30 a.m. Technical and scientific exhibits, lounge room, Murat Temple.

## GENERAL MEETING

### Murat Theater

- 10:30 a.m. Call to order by J. William Wright, M.D., Indianapolis, president Indiana State Medical Association.  
Invocation, Rabbi Morris M. Feuerlicht, Indianapolis.  
Greetings by Glen V. Ryan, M.D., Indianapolis, president of Indianapolis Medical Society, and J. Neill Garber, M.D., Indianapolis, chairman of Committee on Convention Arrangements.  
10:45 a.m. JOHN ROCK, M.D., Clinical Professor of Obstetrics and Gynecology, Harvard Medical School, Boston.  
Subject: "*Human Infertility.*"  
11:15 a.m. WILLIAM B. TUCKER, M.D., Professor of Medicine, University of Minnesota Medical School, and Chief, Tuberculosis Service, Veterans Administration Hospital, Minneapolis.  
Subject: "*Chemotherapy in Tuberculosis.*"



**Noon**

- 12:00 m. Luncheon meeting of examiners for Civil Aeronautics Association and members of Aero Medical Association, Veterans Room, Athenaeum.
- 12:00 m. Luncheon meeting and twenty-fifth anniversary reunion of class of 1927 of Indiana University School of Medicine, Fraternity Room, Athenaeum.
- 12:00 m. Luncheon meeting, Indiana Roentgen Society, Ladies Parlors, Athenaeum.
- 12:00 m. Phi Rho Sigma luncheon, Kneipe Room, Murat Temple.
- 12:00 m. Phi Beta Pi luncheon, Kellersaal, Athenaeum.
- 12:15 p.m. Luncheon meeting of members of State and County Tuberculosis Committees, Directors' Room, Athenaeum. Indiana Chapter of American College of Chest Physicians participating.  
Discussion of organization plans and new infectious disease laws.  
X-ray conference.  
Please bring your interesting films.
- 12:15 p.m. Luncheon meeting of Section on Obstetrics and Gynecology, East Room, Athenaeum.
- 12:30 p.m. Indiana Society of Anesthesiology luncheon meeting, Cantonese Room, LaRue's Supper Club.  
Speaker: GEORGE J. THOMAS, M.D., Pittsburgh.  
Subject: *"The Role of the Anesthesiologist in the Control of Hospital Hazards."*

**Afternoon****SECTION MEETINGS****Section on Medicine**

Chairman, William D. Province, M. D., Franklin  
Vice-chairman, Richard M. Nay, M.D., Indianapolis  
Secretary, Paul L. Stier, M.D., Fort Wayne

**(Murat Theatre)**

- 2:00 p.m. ROBERT L. JOHNSTON, M.D., Bluffton.  
Subject: *"Experience in Management of Peptic Ulcer."*
- 2:15 p.m. Discussion.
- 2:20 p.m. RICHARD R. OWENS, M.D., Muncie.  
Subject: *"Functional Hypoglycemia."*
- 2:35 p.m. Discussion.

- 2:40 p.m. RICHARD N. KENT, M.D., Fort Wayne.  
Subject: *"Diagnosis of Pulmonary Emboli."*
- 2:55 p.m. Discussion.
- 3:00 p.m. LT. ALFRED T. CHAPPEL, M.D., Camp Atterbury.  
Subject: *"Case of Intermittent Left Bundle Branch Block."*
- 3:15 p.m. Discussion.
- 3:20 p.m. GLENN W. IRWIN, Jr., M.D., Indianapolis.  
Subject: *"Place of Radioactive Iodine in Thyroid Disease."*
- 3:35 p.m. Discussion.
- 3:40 p.m. PAUL J. FOUTS, M.D., Indianapolis.  
Subject: *"Recent Advances of Hematology."*
- 3:55 p.m. Discussion.
- 4:00 p.m. RALPH C. WILMORE, M.D., Indianapolis.  
Subject: *"Pulmonary Complications Cardio Spasm."*
- 4:15 p.m. Discussion.
- 4:20 p.m. Election of section officers for 1953.

**Section on Surgery**

Chairman, Norman F. Richard, M.D., Shelbyville  
Vice-chairman, Karl M. Koons, M.D., Indianapolis  
Secretary, Thomas C. Haller, M.D., Crawfordsville

**(Murat Candidates Room)**

- 2:00 p.m. "ACUTE ABDOMINAL EMERGENCIES,"  
—a panel discussion.  
Moderator: J. STANLEY BATTERSBY, M.D., Indianapolis.  
Participants:  
JOSEPH B. DAVIS, M.D., Marion.  
MELL B. WELBORN, M.D., Evansville.  
WILLIAM J. RYAN, M.D., Columbus.  
FRANK M. SCOTT, M.D., South Bend.

- 3 to 4 p.m. Intermission to view technical and scientific exhibits.

- 4:00 p.m. PALMER EICHER, M.D., Indianapolis.  
Subject: *"A New Method of Hip Replacement."*

- 4:20 p.m. Election of section officers for 1953.

**Section on Ophthalmology and  
Otolaryngology**

Chairman, Robert A. Smith, M.D., New Castle  
Vice-chairman, Thomas W. Johnson, M.D., Indianapolis  
Secretary, Edwin W. Dyar, M.D., Indianapolis

**(Basement Lounge)**

2:00 p.m. RALPH J. McQUISTON, M.D., Indianapolis.  
Subject: "*Endaural Radical Mastoidectomy for Chronic Mastoiditis.*"

2:20 p.m. Discussion.

2:30 p.m. CARL J. RUDOLPH, M.D., South Bend.  
Subject: "*Advantages of General Anesthesia in Ophthalmic Surgery.*"

2:50 p.m. Discussion.

3:00 p.m. Intermission to view technical and scientific exhibits.

3:30 p.m. KENNETH L. CRAFT, M.D., Indianapolis.  
Subject: "*Allergic Dermatitis in Ophthalmology and Otolaryngology.*"

3:50 p.m. Discussion.

4:00 p.m. EDMUND L. VAN BUSKIRK, M.D., Lafayette.

Subject: "*Surgical Treatment of Carcinoma of the Eyelids with Plastic Reconstruction of the Eyelids.*"

4:20 p.m. Discussion.

4:30 p.m. Business meeting and election of section officers for 1953.

**Section on Anesthesiology**

Chairman, Edson C. Fish, M.D., South Bend

Vice-chairman, Arthur W. Hull, M.D., Elkhart

Secretary, V. K. Stoelting, M.D., Indianapolis

**(Egyptian Foyer)**

2:00 p.m. GEORGE J. THOMAS, M.D., Associate Professor of Surgery and Chairman of Section on Anesthesiology, University of Pittsburgh School of Medicine, Pittsburgh.  
Subject: "*Fire and Explosion Hazards in Hospitals, and Their Controls.*"

2:30 p.m. Election of section officers for 1953.

**Section on General Practice**

Chairman, Clarence Herzer, M.D., Evansville

Vice-chairman, Bernard Edwards, M.D., South Bend

Secretary, Norman R. Booher, M.D., Indianapolis

**(Egyptian Room)**

2:00 p.m. "HEALTH INSURANCE AS IT RELATES TO THE GENERAL PRACTITIONER,"—a panel discussion.

Moderator: MAURICE V. KAHLER, M.D., Indianapolis.

Participants:

LESTER D. BIBLER, M.D., Indianapolis

WALTER L. PORTEUS, M.D., Franklin

D. D. DICKSON, M.D., Greensburg

WEMPLE DODDS, M.D., Crawfordsville

3:00 p.m. MAURICE V. KAHLER, M.D., Indianapolis  
Subject: "*Hospital Relationships for General Practitioners.*"

3:30 p.m. Business meeting and election of officers for 1953.

4 to 4:30 p.m. Time allowed to view technical and scientific exhibits.

**Section on Obstetrics and Gynecology**

Chairman, C. O. McCormick, Sr., M.D., Indianapolis

Vice-chairman, Ira Cole, M.D., Lafayette

Secretary, Floyd T. Romberger, Jr., M.D., Indianapolis

**(East Room, Athenæum)**

2:00 p.m. "OBSTETRIC HEMORRHAGE,"—a panel discussion.

Moderator: C. O. McCORMICK, SR., M.D., Indianapolis.

Panel members:

SILAS H. STARR, M.D., Clinical Professor of Obstetrics and Gynecology, University of Louisville School of Medicine, Louisville.

DAVID L. SMITH, M.D., Indianapolis.

MAHLON F. MILLER, M.D., Fort Wayne

GERALD W. GUSTAFSON, M.D., Indianapolis.

PIERCE MacKENZIE, M.D., Evansville.

3:00 p.m. "GYNECOLOGIC HEMORRHAGE," — a panel discussion.

Moderator: SPRAGUE H. GARDINER, M.D., Indianapolis.

Panel members:

JOHN ROCK, M.D., Boston.

ALEXANDER W. CAVINS, M.D., Terre Haute.

DAVID A. BICKEL, M.D., South Bend.

CARL P. HUBER, M.D., Indianapolis.

FRANK W. PEYTON, M.D., Lafayette.

4:00 p.m. Election of section officers for 1953.



## Section on Preventive Medicine and Public Health

### Organization Committee:

Gerald F. Kempf, M.D., Indianapolis  
F. R. Nicholas Carter, M.D., South Bend  
Minor Miller, M.D., Evansville  
L. E. Burney, M.D., Indianapolis  
L. L. Renbarger, M.D., Marion  
William E. Amy, M.D., Corydon

### (Little Auditorium, Athenaeum)

2:00 p.m. HAVEN EMERSON, M.D., Professor Emeritus of Public Health Administration, Columbia University College of Physicians and Surgeons, New York.

Subject: *"Roles of the Family Physician and the Local Health Officer in the Public Health Program."*

2:30 p.m. "PURPOSES AND ORGANIZATION OF THE SECTION ON PREVENTIVE MEDICINE AND PUBLIC HEALTH,"—panel discussion.

### Participants:

GERALD F. KEMPF, M.D., Indianapolis  
F. R. NICHOLAS CARTER, M.D., South Bend  
MINOR MILLER, M.D., Evansville  
L. E. BURNEY, M.D., Indianapolis  
L. L. RENBARGER, M.D., Marion  
WILLIAM E. AMY, M.D., Corydon

Election of section officers for 1952 and 1953.

3:00 p.m. THOMAS FRANCIS, Jr., M.D., Ann Arbor, Michigan.

Subject: *"New Developments in Virus Diseases."*

5:30 p.m. Exhibits close.

### Evening

6:00 p.m. Stag dinner-reunion, Class 1938, Indiana University School of Medicine, Columbia Club.

8:00 p.m. President's night, Murat Theater.  
Address, J. WILLIAM WRIGHT, M.D., Indianapolis, President.

Concert: Purdue University Varsity Glee Club.

Thursday, October 30, 1952

### Morning

7:30 a.m. Final meeting of House of Delegates, Kellersaal, Athenaeum. (Breakfast meeting).  
Business meeting in Little Auditorium, Athenaeum.

Meeting of Council immediately following adjournment of House of Delegates.

8:00 a.m. Registration continues, lounge room, Murat Temple. Purchase your banquet tickets at the registration desk.

8:30 a.m. Technical and scientific exhibits, lounge room, Murat Temple.

## GENERAL MEETING

### Murat Theater

11:00 a.m. PAUL W. SCHAFER, M.D., Professor and Chairman, Department of Surgery, University of Kansas School of Medicine, Kansas City, Kansas.

Subject: *"Treatment of Shock in Major Disaster without Blood or Plasma."*

11:30 a.m. BRUCE K. WISEMAN, M.D., Professor and Chairman, Department of Medicine, Ohio State University College of Medicine, Columbus.

Subject: *"Problems and Dangers of Transfusion."*

### Afternoon

## GENERAL MEETING

### Murat Theater

1:30 p.m. VICTOR M. SBOROV, M.D., Chief, Department of Hepatic and Metabolic Diseases, Army Medical Service Graduate School, Walter Reed Army Medical Center, Washington, D. C.

Subject: *"Infectious Hepatitis."*

1:50 p.m. ARTHUR J. PATEK, Jr., M.D., Assistant Clinical Professor of Medicine, Columbia University College of Physicians and Surgeons, New York.

Subject: *"Cirrhosis of the Liver."*

2:10 p.m. ROBERT M. ZOLLINGER, M.D., Professor and Chairman, Department of Surgery, Ohio State University College of Medicine, Columbus.

Subject: *"Indications for Surgery in Jaundiced Patients."*

2:30 p.m. Intermission to view technical and scientific exhibits.

3 to 4 p.m. "THE MANAGEMENT OF LIVER DISEASES,"—a panel discussion.

Moderator: J. O. RITCHEY, M.D., Indianapolis.

Participants:

VICTOR M. SBOROV, M.D., Washington, D. C.

ARTHUR J. PATEK, M.D., New York

ROBERT M. ZOLLINGER, M.D., Columbus, Ohio

R. MORTON BOLMAN, M.D., Fort Wayne

3:30 p.m. Exhibits close.

5:00 p.m. Reception for members of Fifty-Year Club, Sky Room, Ninth Floor, Claypool Hotel.  
Speaker: PROFESSOR GEORGE E. DAVIS, Director, Adult Education, Purdue University.

## Evening

6:30 p.m. Annual dinner and dance, Indiana Ballroom.

Presiding officer, J. WILLIAM WRIGHT, M.D., president, Indiana State Medical Association.

Invocation, Reverend Jean S. Milner, Pastor, Second Presbyterian Church, Indianapolis.  
Recognition of Fifty-Year Club members.  
Award to General Practitioner of the Year.  
Speaker: EDWARD J. McCORMICK, M.D., president-elect, American Medical Association, Toledo.

Presentation of certificate of merit and plaque to J. WILLIAM WRIGHT, M.D., president 1952, by Paul D. Crimm, M.D., president, 1953.

## Women's Entertainment

### Tuesday, October 28, 1952

- 8:00 a.m. Registration starts, lounge room, Murat Temple. (Purchase your luncheon and dinner tickets when you register.)
- 6:00 p.m. Dinner, Kellersaal, Athenaeum. Past presidents of the Woman's Auxiliary to the Indiana State Medical Association will be special guests.
- 8:15 p.m. Entertainment, in conjunction with the Indiana State Medical Association, Murat Theater.

### Wednesday, October 29, 1952

- 8:00 a.m. Registration continues, lounge room, Murat Temple.
- 10:00 a.m. Board meeting, Woman's Auxiliary to the Indiana State Medical Association, Ballroom, Columbia Club.
- 12:00 m. Luncheon, honoring Mrs. Ralph Eusden, Long Beach, California, president, Woman's Auxiliary to the American Medical Association, Columbia Club.  
Fashion revue.
- 8:00 p.m. Concert, Purdue University Varsity Glee Club, Murat Theater.

MRS. RALPH B. EUSDEN, president of the Woman's Auxiliary of the American Medical Association, will be the guest of honor at a luncheon in the Columbia Club given by the Woman's Auxiliary of the Indiana State Medical Association.



Mrs. Eusden

### Thursday, October 30, 1952

- 8:00 a.m. Registration continues, lounge room, Murat Temple.
- 1:00 p.m. Dutch treat luncheon, private dining room, Russet Cafeteria.
- 6:30 p.m. Annual dinner and dance in conjunction with the Indiana State Medical Association, Indiana Ballroom.



# NEED A HOTEL RESERVATION FOR THE STATE MEETING?

(Indianapolis, October 28, 29, 30, 1952)

## Start Calling Doctor Gillespie!

Don't stay at home because you haven't a hotel room for the I.S.M.A. convention—Dr. Jacob E. Gillespie and his Housing Committee will get you a room.

Write to Doctor Gillespie . . . not to a hotel . . . if you need a room. Use form below.

### TIME OF EVENTS

#### TUESDAY, OCTOBER 28

Instructional Courses, Stag Party, Golf, Trapshoot, Party for Women.

#### WEDNESDAY, OCTOBER 29

Scientific Program, entertainment at night for doctors and wives, Murat Theater.

#### THURSDAY, OCTOBER 30

Scientific Program, reception for Fifty Year Club, annual dinner and dance.

Hotels	Rates (Start)	
	Single	Double
Antlers, 750 N. Meridian.....	\$4.25	\$6.25
Barnes, 233 McCrea Place.....	\$3.00	\$4.00
Barton, 505 N. Delaware.....	\$2.75	\$4.00
Claypool, 14 N. Illinois.....	\$4.60	\$6.30
Harrison, 51 N. Capitol.....	\$4.00	\$6.00
Jones, 248 S. Illinois.....	\$2.50	\$4.50
Lincoln, 117 W. Washington.....	\$4.50	\$6.75
Linden, 311 N. Illinois.....	\$2.00	\$3.50
Marott, 2625 N. Meridian.....	\$8.00	\$10.00
New English, 6 W. Michigan.....	\$3.00	\$5.00
Pennsylvania, 947 N. Penn.....	\$3.75	\$5.50
Riley, 155 W. 16th.....	\$2.50	\$4.50
Severin, 201 S. Illinois.....	\$4.50	\$6.50
Sheffield, 958 N. Pennsylvania.....	\$4.00	\$7.00
Spink Arms, 410 N. Meridian.....	\$3.50	\$6.00
Warren, 123 S. Illinois.....	\$4.75	\$6.75
Washington, 34 E. Washington....	\$4.25	\$5.75

### HOTEL RESERVATION BLANK

Clip and Mail this coupon to Dr. Jacob E. Gillespie, 523 Hume Mansur Bldg., Indianapolis 4, Ind.

You are requested to reserve the following accommodations during the period of the Annual Meeting of the Indiana State Medical Association, October 28, 29 and 30, or for such other period as may be indicated herein.

- ☐ Single Room with bath
- ☐ Double Room with bath
- Price:.....
- ☐ Twin Bed Room with bath
- ☐ Suite

Arrival date ..... A. M. .... P. M.

Departure date ..... A. M. .... P. M.

Hotel Choices

Name ..... First .....

Address ..... Second .....

..... Third .....

..... Fourth .....

## Calendar of Special Events

Pre-convention meetings will be held by the **Executive committee** at 3 p.m. Monday, October 27, in the Columbia Club and the **Council** at a 6:30 dinner meeting in the Columbia Club that evening.

**House of Delegates** will breakfast at 7:30 Tuesday morning in the Kellersaal, Athenaeum.

**Committee on Industrial Health** will have breakfast at 7:30, Tuesday in Club Room J, Hotel Lincoln.

**Annual Golf Tournament** opens at 10:00 Tuesday morning at Meridian Hills Country club. Medal play, based on low gross and handicap.

At 10:00 Tuesday morning those who prefer trapshooting may attend the **Annual Trapshoot** at Indiana Gun Club. Those who wish to enter should contact Dr. Harold C. Adkins, 409 East 30th Street, Indianapolis 5.

**Editorial Board** members are scheduled to meet at 10 a.m. Tuesday morning, October 28, in Officers' Room, Murat Temple.

**Indiana Association of Pathologists** will have a luncheon meeting in the Ladies' Parlors, Athenaeum, at 12 noon, Tuesday, October 28.

**Committee on Mental Health** will have a Tuesday noon luncheon at the rear of the Palm Room, Athenaeum.

**Phi Chi luncheon** at 12 Tuesday noon, October 28, will be in the Veterans' Room, Athenaeum. Dr. Carl B. Spath, Jr. is in charge.

A reception and dinner for **women physicians** will be held at 6 p.m. Tuesday in the Indianapolis Athletic Club.

A **buffet supper, smoker and stag party** is to be held at 6 p.m., Tuesday, October 28, in the Dining Room, Murat Temple.

**Class of 1906** of Indiana Medical College will hold a dinner meeting at 6 p.m., Tuesday, October 28, in Fraternity Room, Athenaeum.

**Past Presidents of the Woman's Auxiliary** of the Indiana State Medical Association will be guests at a dinner at 6 p.m. Tuesday in the Kellersaal, Athenaeum.

Dinner meeting of the **Indianapolis Obstetrical and Gynecological Society** is scheduled for 7 p.m. Tuesday, October 28, in the Indianapolis Athletic Club. John Rock, M.D., Boston, will be the speaker. For dinner reservations, contact Dr. C. O. McCormick, Jr, 621 Hume Mansur Building, Indianapolis 4, Indiana.

**Physicians, their wives and guests** will be entertained at a special program at Murat Theater at 8:15 p.m., Tuesday, October 28.

**Greetings** will be extended to the members of Indiana State Medical Association at the first General Meeting Wednesday morning in Murat Temple by **Dr. Glen V. Ryan**, president of Indianapolis Medical Society and chairman of the reception committee, and by **Dr. J. Neill Garber**, Indianapolis, chairman of the committee on Convention Arrangements. Doctor Ryan, as president of the host society, will speak as the representative of the members of the convention committees who are sparing no effort to make the 103rd Annual Session of ISMA a complete success.



Reservations for luncheon meeting of the **Section on Obstetrics and Gynecology** on Wednesday, October 29, at 12:15 noon, East Room, Athenaeum, may be made with Dr. Floyd T. Romberger, Jr., 3440 North Meridian Street, Indianapolis 8, or telephone Wabash 9361. Tickets may also be procured at convention registration desk.

**Examiners for Civil Aeronautics Association** and members of **Aero Medical Association** will meet in Veterans' Room, Athenaeum, at 12 noon Wednesday for luncheon.

Luncheon and twenty-fifth reunion of **Class of 1927, I. U. School of Medicine**, to be held at noon, Wednesday, October 29, in Fraternity Room, Athenaeum.

A fashion revue will follow the luncheon Wednesday noon, honoring Mrs. Ralph B. Eusden, president of Woman's Auxiliary of the American Medical Association. It will be held in the Columbia Club.

**Indiana Roentgen Society** luncheon meeting scheduled for noon Wednesday, Ladies' Parlors, Athenaeum. Warren W. Furey, M.D., Chicago, speaker.

**Phi Rho Sigma** luncheon will be held in Kneipe Room, Murat Temple, and **Phi Beta Pi** luncheon in Kellersaal, Athenaeum. Both are set for 12 noon, Wednesday, October 29.

**State and County Tuberculosis Committees** and **Indiana chapter, American College of Chest Physicians** will meet for luncheon at 12:15 Wednesday in Directors' Room, Athenaeum.

**Indiana Society of Anesthesiology** plans luncheon meeting at 12:30 Wednesday noon in Cantonese Room, LaRue's Supper Club. Dr. George J. Thomas, Pittsburgh, to speak.

First reunion of the **Class of 1938 at Indiana University School of Medicine** on its fourteenth anniversary will be held at a stag dinner at 6 p.m. Wednesday, October 29, in the Columbia Club.

**President's Night**, Murat Theater, will be at 8 p.m. Wednesday evening. Dr. J. William Wright, ISMA president, will speak and the Purdue Glee club will sing.

**House of Delegates** breakfast at 7:30 Thursday morning in the Kellersaal, Athenaeum, will be followed by meeting of the Council.

**Fifty Year club** members will be guests at a reception at 5 p.m. Thursday, October 30, in the Sky Room, Ninth Floor, Claypool Hotel.

**The Annual Dinner and Dance** is the final event on the 1952 convention program. It will be held in the Indiana Ballroom at 6:30 Thursday evening. Awards will be made and the President-elect of the American Medical Association, Edward J. McCormick, M.D., Toledo, will be the speaker.

### *Prescription for Longevity*

A clue to long life comes from Dr. Morris Fishbein. At the American Medical Association convention, Dr. Fishbein gave his prescription for health and long life. His "five lows" for longevity are: (1) low blood pressure; (2) low pulse rate; (3) low basal metabolism; (4) low diet in total calories and (5) low threshold for humor. He advised this recipe be blended with equanimity and imperturbability.

## ORDER YOUR TICKETS FOR THE 1952 INSTRUCTIONAL COURSES NOW!

The schedule of classes for the 1952 Instructional Courses, offered as a feature of the Annual Session of the Indiana State Medical Association, at Murat Temple, Indianapolis, is now complete. All classes are on Tuesday, October 28, 1952.

(Attendance at these classes by members of the Indiana Academy of General Practice will be accepted as postgraduate training credit by that organization.)

Admission to each class will be by ticket, and not more than thirty will be admitted to any class. The cost is \$1.00 per class with a maximum charge of \$3.00 for three or more classes. Plan your course to include five classes. (And please note second choices.) Enclose your check made payable to "Instructional Course Committee." Do it now! Classes are filled early!

### INSTRUCTIONAL COURSE SCHEDULE

Hrs.	Room A	Room B	Room C	Room D	Room E	Room F
11 to 12	Bedside and Office Diagnosis of Cardiac and Vascular Problems. Course 1	Pediatric and Infant Feeding Problems. Course 2	The Diagnosis and Treatment of Common Skin Diseases. Course 3	The Treatment of Anemias and Allied Conditions. Course 4	Management of The Neurotic. Course 5	Constipation—Diarrhea—Indigestion. Course 6
<b>NOON RECESS</b>						
1 to 2	The Demonstration of a Physical and Neurological Examination. Course 7	Obstetrical Emergencies. Course 8	Bedside and Office Diagnosis of Cardiac and Vascular Problems. Course 9	Differential Diagnosis of Fatigue States. Course 10	The Treatment of Burns and Shock. Course 11	The Management of Anorectal Conditions. Course 12
2 to 3	Salt Metabolism in Heart Failure and Hypertension. Course 13	Cancer. Course 14	Shoulder and Upper Extremity Pain. Course 15	The Overactive and Inactive Thyroid. Course 16	Management of the Elderly Course 17	Diagnosis and Treatment of Respiratory Diseases. Course 18
3 to 4	The Newer Management of Coronary Disease, Rheumatic Fever and Congestive Failure. Course 19	The Diagnosis and Management of Common Gynecological Problems. Course 20	The Backache Problem. Course 21	Vertigo and Allied States. Course 22	The Diagnosis and Management of Comatose States. Course 23	The Diagnosis and Treatment of Common Skin Diseases. Course 24
4 to 5	The Newer Drugs. Course 25	Premarital and Marital Counseling. Course 26	The Headache Problem. Course 27	The Management of Diabetes Mellitus. Course 28	How to Improve Your Own Public Relations. Course 29	Office Diagnosis and Treatment of Common Genitourinary Diseases. Course 30

Cut on Dotted Line

### APPLICATION BLANK

Instructional Course Committee,  
Indiana State Medical Association,  
1021 Hume Mansur Building,  
Indianapolis 4, Indiana.

Enclosed find check for \$1.00; \$2.00; \$3.00. Please reserve tickets for the following Instructional Courses:

First choice.....	11:00 A.M. No.:	1:00 P.M. No.:	2:00 P.M. No.:	3:00 P.M. No.:	4:00 P.M. No.:
Second choice.....	11:00 A.M. No.:	1:00 P.M. No.:	2:00 P.M. No.:	3:00 P.M. No.:	4:00 P.M. No.:

(Insert course numbers plainly, please.)

I will pick up my tickets at the Registration Desk, October 28, 1952.

Signed: \_\_\_\_\_ M.D.

Address: \_\_\_\_\_

Next Year Please Include \_\_\_\_\_  
Classes on These Topics \_\_\_\_\_



## Official Call to the House of Delegates

The next annual session of the Indiana State Medical Association will be held at the Murat Temple, Indianapolis, October 28, 29 and 30, 1952.

The House of Delegates will be constituted as follows: Marion County, eighteen delegates; Lake County, six delegates; Allen County, four delegates; St. Joseph County, four delegates; Vanderburgh County, four delegates; Delaware-Blackford, Harrison-Crawford, Bartholomew-Brown, Daviess-Martin, Dearborn-Ohio, Elkhart, Fayette-Franklin, Fountain-Warren, Jasper-Newton, Jefferson-Switzerland, Madison, Owen-Monroe, Parke-Vermillion, Tippecanoe, Vigo and Wayne-Union County Societies, each two delegates; the other sixty-three county societies, each one delegate; thirteen councilors; and the ex-presidents, namely: C. S. Bond, W. H. Stemm, E. M. Shanklin, Charles N. Combs, George R. Daniels, Charles E. Gillespie, F. S. Crockett, J. H. Weinstein, R. L. Sensenich, Herman M. Baker, Karl R. Ruddell, A. M. Mitchell, M. A. Austin, Carl H. McCaskey, J. T. Oliphant, N. K. Forster, Floyd T. Romberger, Cleon A. Nafe, Augustus P. Hauss, C. S. Black and Alfred Ellison; and ex-officio, the president, president-elect, executive secretary, and the treasurer of the association, and the delegates to the American Medical Association, all without power to vote, except in case of a tie vote, when the president shall cast the deciding vote.

Blank credentials have been sent by the secretary to each county society, and the properly executed credentials should be mailed to the Indiana State Medical Association, 1021 Hume Mansur Building, Indianapolis 4, Indiana, or brought to the session. No delegate will be seated unless wearing the official badge.

The House of Delegates will convene promptly at 7:30 a.m., Tuesday, October 28, in the Athenaeum, and again at 7:30 a.m., Thursday, October 30, in the Athenaeum. (Breakfast meetings.)

The order of business will be as follows:

1. Call to order by the president.
2. Roll call and seating of qualified delegates.
3. Reading of the minutes of previous meetings.
4. Appointment of reference committees.
5. Address of president-elect.
6. Report of executive secretary.
7. Report of the treasurer.
8. Report of the chairman of the Council.
9. Reports of councilors.
10. Reports of standing and special committees:
  - (1) Executive Committee.
  - (2) Board of Appeals on Patient-Physician Relations.

- (3) Conference of County Medical Society Officers.
- (4) Constitution and By-Laws.
- (5) Convention Arrangements.
- (6) Industrial Health.
- (7) Medical Education and Hospitals.
- (8) Public Policy and Legislation.
- (9) Public Relations.
- (10) Publicity.
- (11) Rural Health.
- (12) Scientific Exhibits.
- (13) Scientific Work.
- (14) Alcoholics Study.
- (15) Auditing.
- (16) Cancer.
- (17) Chronic Illness.
- (18) Civil Defense.
- (19) Crippled Children Services.
- (20) Diabetes.
- (21) Foot Hygiene.
- (22) Hard of Hearing.
- (23) Heart Disease.
- (24) Indiana A.M.A. Campaign Coordinating Committee.
- (25) Indiana Inter-Professional Health Council.
- (26) Infantile Paralysis.
- (27) Instructional Courses.
- (28) Maternal and Child Health.
- (29) Permanent Study Committee on Medical Care Insurance.
- (30) Medical and Nursing School Scholarships.
- (31) Mental Health.
- (32) Military Manpower.
- (33) Necrology.
- (34) Physician-Hospital Relationship.
- (35) School Health and Physical Education.
- (36) State Fair.
- (37) Traffic Safety.
- (38) Tuberculosis.
- (39) Venereal Disease.
- (40) Veterans Affairs and Rehabilitation.
- (41) Journal Publication.

The election of officers will be the first order of business at the second meeting of the House of Delegates. In addition to the regular officers, the terms of the following officers expire December 31, 1952, and their successors must be elected at the session: Delegates to the American Medical

Association to succeed H. G. Hamer, Indianapolis, and Alfred Ellison, South Bend; and alternates Karl R. Ruddell, Indianapolis, and E. S. Jones, Hammond.

Delegates from the third, sixth, ninth and twelfth districts are reminded that the terms of their councilors will expire December 31, 1952, and the new councilors should be elected to succeed the following:

Third District: William H. Garner, New Albany.  
Sixth District: W. U. Kennedy, New Castle.  
Ninth District: Wemple Dodds, Crawfordsville.  
Twelfth District: M. B. Catlett, Fort Wayne.

Some of these elections already may have been held, but they should be reported to the House of Delegates at this session for confirmation.

JAMES A. WAGGENER,  
*Executive Secretary.*

## Reports of Officers and Committees

### EXECUTIVE SECRETARY

Your executive secretary desires your permission to use this report as a means of paying tribute to the fine spirit of cooperation that has made the Indiana State Medical Association the most outstanding in the nation. The first year is always a trying one for a new employee, especially when realization is paramount that he is charged with the responsibility of carrying on the high traditions of his predecessors.

It is with utmost appreciation and with a deep sense of sincerity that I use this report as a means of conveying to the members of the Indiana State Medical Association my personal thanks for the innumerable offers of assistance, the many courtesies, and the many willing hands that have been so generous in the giving of their time and effort to make possible whatever success has been attained.

The problems faced by your association have not diminished during the past year, on the other hand they have shown an increase and will in all probability continue to multiply for the next few years. It is regrettable that you fine gentlemen who make up the Indiana State Medical Association have been forced to take time from your busy professional schedules to concern yourselves with politics and a host of other activities which just so few short years ago did not require your time.

The battle against socialized medicine has not been won,— it has been delayed. You have received the plaudits of your fellowmen throughout the nation for the valiant piece of work done by you in your fight against this threat.

Today, there are still those who have not given up the fight, although they have been hurt, but as we are meeting here today, they are licking their wounds and planning a new attack.

The International Labor Organization, an adjunct of the United Nations in June of 1952 adopted a treaty which would very easily throw our nation into a state of socialism. By a mere vote of the Senate we can lose all our gains should this treaty be ratified by this nation, therefore, this move on

the part of the international socializers, coupled with the fringe legislation designed to bring socialized medicine upon the profession, in piecemeal fashion, will require the alertness of every physician if the private practice of medicine is to continue as it is known today.

The chiropractic issue will again present itself during the coming legislature. Today, they are busy organizing lay associations to fight their battle for them before the legislators of our state. Here is another group with everything to gain and nothing to lose, so we cannot say we have defeated them, we have only delayed their program. I would like to quote from the September issue of *The State Union Labor*, a newspaper holding itself forth as representing labor in this state. On the front page in bold type and boxed to call it to the attention of all readers is the following "No chiropractor has been issued a license to practice in Indiana since 1927, no matter what chiropractic college in the United States they graduated from. The Indiana Layman Chiropractic Association organized in 1950 aims to sponsor proper legislation for the advancement and future of chiropractic in this state."

Another development facing the profession in the coming legislature is a move to change the provision of the Workman's Compensation Act so an employee may go to the physician of his choice for treatment, rather than being required, as it is now done, to visit the plant or insurance physician. While the Code of Ethics of the profession clearly sets forth that the person paying for the medical care shall have the right to designate the physician to render the service, labor holds they should be permitted "free choice" of physician. In their argument they point to the profession's recent campaign against socialized medicine, and to one point of the campaign on "free-choice" of physician, in which we said, that should compulsory government health insurance become a reality, the government would have the right to name the physician to whom the public would be forced to go for their medical care. This is the very condition that exists now under the present work-



man's compensation program, they say, and ask, "So how can the medical profession oppose our wishes to obtain for our members 'free choice' of physician in compensation cases?" If it is not right for the government to select your physician, neither is it right for the employer or the insurance company to select the physician, they add. This issue is one on which the profession can be placed in an untenable position.

These points are mentioned only for the purpose of informing you of some of the problems to be faced by the Association in the coming year. It is also mentioned in the hope that it will encourage the profession as a whole to visit the election polls November 4, and cast their ballot for men who are concerned over the course of events,—men who will exert their every effort to maintain our present high standards and to place us once again, firmly, on the road leading away from the jaws of socialism.

Your headquarters office has endeavored to carry out the many assignments given it during the year by the officers and committees of the Association. The staff has been cooperative and worked diligently in the interest of the association, otherwise the great volume of work could not have been completed.

Your committees have functioned well and as you review their various reports you will find their year has been a busy and fruitful one.

Your secretary has accompanied the President of the Association to all but one of the Councilor District meetings, and the one was missed only because there were three scheduled on the same day,—two were made but not the third. In addition, as many medical societies have been visited as time would permit and it is my hope that as time progresses it will be possible to visit each county society and to become better acquainted with the problems of the societies, and in this way place the association in a position to be of better service to the membership as a whole.

This report would not be complete without paying tribute to the officers of the association. You can well be proud of the time and effort they have put forth in behalf of the association. During the past year, not one officer has hesitated in the least to give of his time and his effort. Certainly this demonstrates the exceptionally high caliber of the association, when such men have willingly placed their shoulders to the wheel and pushed hard to make your association the success it is today.

Feeling that your association should be of utmost service to its members, a field secretary was added during the past year. This man is spending his entire time in the field, offering his services in any way they might be used, whether by the individual physician or the society. It is hoped that as time progresses you will use him fully, for he is at your service, just as your entire staff is at your

service. We hope through this service to be better able to interpret your association's program and problems to the membership and at the same time to seek your counsel and advice and to assist you in any way we can.

As your secretary looks ahead to 1953, it is with eager anticipation, grateful for the privilege of being associated with the finest group of men in the nation.

JAMES A. WAGGENER, *Executive Secretary*

## TREASURER'S REPORT

Since the report of the accountants as of Dec. 31, 1951, investments in the Medical Defense Fund have been increased by \$1,000. This amount was withdrawn from the Medical Defense Fund checking account and invested in U. S. Savings Bonds Series K. Also, investments in the General Fund have been increased by \$25,000. This amount was withdrawn from the General Fund checking account and invested in U. S. Savings Bonds Series K.

The bank balance in the General Fund, Medical Defense Fund, The Journal Fund and Petty Cash Fund as of July 23, 1952 may be found in the report of the auditing committee.

The following is a detailed report prepared by Geo. S. Olive & Co. of Indianapolis showing the financial status of the association as of Dec. 31, 1951.

ROY V. MYERS, M.D., *Treasurer*

January 9, 1952

The Council,  
Indiana State Medical Association,  
Indianapolis, Ind.

Gentlemen:

We have examined the accounts and financial records of the Indiana State Medical Association as of December 31, 1951, and the statements of income and expense, and fund balances for the year then ended, on a cash receipts and disbursements basis. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the accompanying statement of assets, all funds, and related statements of income and expense, on a cash receipt and disbursements basis, present fairly the position of the Indiana State Medical Association at December 31, 1951, and the results of its operations for the year then

ended, in conformity with generally accepted accounting principles applied on a consistent basis.

Yours very truly,

Geo. S. Olive & Co.

Certified Public Accountants

#### Exhibit A

#### INDIANA STATE MEDICAL ASSOCIATION

##### Analysis of Increase in Assets, All Funds Year Ended December 31, 1951

TOTAL ASSETS, DECEMBER 31, 1951	\$119,223.28
TOTAL ASSETS, DECEMBER 31, 1950	75,298.29
NET INCREASE	\$ 43,924.99

Arising from the following sources:

Excess of operating cash receipts over operating cash disbursements, year ended December 31, 1951:

General fund—exhibit C.  
Receipts ---\$135,445.95  
Disbursements --- 100,263.91

35,182.04

Add: Increase in petty cash 500.00

\$ 35,682.04

The Journal of the Indiana State Medical Association — exhibit D:

Receipts -- 41,413.30  
Disbursements --- 35,354.10

6,059.20

Medical Defense fund—exhibit E:

Receipts --- 4,708.75  
Disbursements --- 2,525.00

2,183.75

NET INCREASE \$ 43,924.99

#### Exhibit B

#### INDIANA STATE MEDICAL ASSOCIATION

##### Statement of Assets, All Funds, at December 31, 1951

##### GENERAL FUND:

Cash on deposit—Exhibit C---\$40,715.55  
Petty cash fund ----- 1,000.00  
Investments:  
U. S. Treasury  
bonds ----- \$ 5,000.00  
U. S. Savings  
bonds ----- 36,000.00

41,000.00

Total general fund \$ 82,715.55

#### THE JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION:

Cash on deposit—exhibit D---

14,566.28

##### MEDICAL DEFENSE FUND:

Cash on deposit—Exhibit E--- 3,941.45

Investments:

U. S. Treasury  
bonds ----- 5,000.00  
U. S. Savings  
bonds ----- 13,000.00

18,000.00

Total Medical Defense Fund 21,941.45

TOTAL ASSETS, ALL FUNDS—Exhibit A \$119,223.28

#### Exhibit C

#### INDIANA STATE MEDICAL ASSOCIATION

##### Comparative Statement of Cash Receipts and Disbursements, Years Ended December 31, 1951, and December 31, 1950

##### General Fund

	Year Ended		
	December 31, 1951	December 31, 1950	Increase (Decrease)

##### CASH BALANCE AT BEGINNING OF YEAR

	\$ 5,533.51	\$ 8,964.01	\$ (3,430.50)
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##### RECEIPTS:

Membership dues	115,370.00	117,682.50	(2,312.50)
Income from exhibits	14,675.00	7,938.50	6,736.50
Interest income	1,172.50	1,112.50	60.00
Proceeds from matured bonds	4,000.00	1,000.00	3,000.00
Egbert medical scholarship fund	200.00	100.00	100.00
Centennial book fund	14.45	63.30	( 48.85)
Miscellaneous income	14.00	---	14.00
Postgraduate study fees	---	430.00	( 430.00)
Krannert Nurse Scholarship fund	---	1,200.00	(1,200.00)
Instructional courses	---	36.02	( 36.02)

Total receipts

—Exhibit A	\$135,445.95	\$129,562.82	\$ 5,883.13
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##### BEGINNING BALANCE PLUS

CASH RECEIPTS	140,979.46	138,526.83	2,452.63
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##### DISBURSEMENTS:

Transfer of applicable portion of dues to The Journal of the Indiana State Medical Association	10,896.00	11,004.00	( 108.00)
Medical Defense Fund—Exhibit E	4,318.75	4,327.75	( 9.00)
Purchase of securities	4,000.00	1,000.00	3,000.00
Headquarter's office expense	21,155.03	21,106.05	48.98



Publicity committee -----	1,703.55	730.37	973.18
Public policy -----	2,374.83	6,846.60	( 4,471.77)
Council -----	1,563.46	1,105.31	458.15
Officers -----	1,893.40	2,897.51	( 1,004.11)
Annual session ---	11,800.25	7,399.85	4,400.40
Miscellaneous committees -----	8,985.21	9,898.97	( 913.76)
Federal insurance contributions tax	242.37	217.78	24.59
Indiana unemployment compensation and excise tax -----	421.31	435.58	( 14.27)
Refunds of dues ---	----	38.00	( 38.00)
Refunds of exhibit rent -----	----	77.50	( 77.50)
Fifty-year club ---	324.08	35.04	289.04
Increase in petty cash fund -----	500.00	---	500.00
Woman's Auxiliary to I.S.M.A. -----	77.13	218.35	( 141.22)
A.M.A. Coordinating Committee --	29,950.08	64,883.75	(34,933.67)
A.M.A. dues -----	----	612.50	( 612.50)
General Practitioner Award -----	58.46	58.10	.36
Miscellaneous -----	----	100.31	( 100.31)
Total disbursements—Exhibit A -----			
A -----	100,263.91	132,993.32	(32,729.41)

CASH BALANCE AT  
END OF YEAR \$ 40,715.55 \$ 5,533.51 \$ 35,182.04

Exhibit D  
INDIANA STATE MEDICAL ASSOCIATION  
Statement of Cash Receipts and Disbursements,  
Year Ended December 31, 1951

The Journal of the Indiana State Medical Association  
BALANCE, JANUARY 1, 1951-----\$ 8,507.08

RECEIPTS:			
Subscriptions—members—			
Exhibit C -----	\$10,896.00		
Subscriptions—non-members -----	440.00		
Advertising -----	28,979.97		
Collections on accounts receivable -----	307.32		
Single copy sales -----	226.00		
Electrotypes -----	228.01		
Sale of civil defense reprints-----	336.00		
Total receipts—Exhibit A -----			
		41,413.30	
		49,920.38	

DISBURSEMENTS:			
Salaries -----	\$ 7,600.00		
Printing -----	23,735.75		
Office postage -----	264.33		
Journal postage -----	632.51		
Advertising commissions -----	172.67		
Electrotypes -----	940.96		
Press clippings -----	125.86		
Office supplies -----	247.35		
Rent -----	480.00		
Electricity -----	20.88		
Telephone and telegraph -----	225.03		
Federal insurance contributions	112.56		
Indiana unemployment compensation and excise -----	224.98		
Art work -----	75.00		
Civil defense reprints -----	340.75		
Miscellaneous -----	155.47		
Total disbursements—			
Exhibit A -----		35,354.10	

BALANCE, DECEMBER 31, 1951—  
EXHIBIT B -----\$14,566.28

Exhibit E INDIANA STATE MEDICAL ASSOCIATION Statement of Cash Receipts and Disbursements, Year Ended December 31, 1951	
Medical Defense Fund	
BALANCE, JANUARY 1, 1951-----	\$1,757.70
RECEIPTS:	
Transfer of applicable portion of dues from the general fund—	
Exhibit C -----	\$4,318.75
Interest income -----	390.00
Total receipts—Exhibit A-----	
	4,708.75
	6,466.45

DISBURSEMENTS:	
Malpractice fees -----	725.00
Attorney fees -----	1,800.00
Total disbursements—Exhibit A-----	
	2,525.00
BALANCE, DECEMBER 31, 1951—Exhibit B-----	\$3,941.45

CHAIRMAN OF THE COUNCIL

The Council of the Indiana State Medical Association has experienced a year of activity during which we have witnessed a marked increase in participation on the part of many of our committees. The minutes of the various meetings of the Council have been published previously in THE JOURNAL so I will not go into detail in reviewing the many matters of business transacted. Copies of the proceedings will be given the Reference Committee for its use in reviewing, in detail, our work during the year.

I would, at this time, like to commend the members of the Council and the Officers of the Association for their cooperation and interest in the many matters that have come before us. Promptness and business-like methods have enabled us to handle the great volume of business expeditiously.

A few of the more important matters referred to the Council should be mentioned here as a matter of emphasis.

The Council approved the request of the Committee on Industrial Health for publication of a pamphlet entitled, "Medical Directives for the Nurse in Industry." It might be well to call to the attention of the membership that this committee was the first in the nation to work out such directives. Requests have been received from throughout the United States and its territorial possessions for copies of this publication. This pamphlet has served to spread the name of the Indiana State Medical Association throughout the nation, giving further evidence of the progressiveness of our Association.

Following much discussion the Council, upon the recommendation of many, approved the reestablishment of the Section meetings for our Annual meeting in the hope this would encourage a larger attendance at our scientific sessions.

Feeling the remarks of many of our members were basically true, the Council established rules governing the introduction of resolutions during the sessions of the House of Delegates. Many

thought the membership as a whole and the delegates in particular were placed at a disadvantage when asked to take action upon resolutions upon which there had not been sufficient notice to permit discussion by the component societies and the membership as a whole. To afford our members a better opportunity to express themselves upon matters of policy of the Association, the Council has ruled that resolutions be forwarded to the headquarters office in sufficient time to permit discussion at the society level and to permit the delegate or delegates to be fully informed of the wishes of the membership before being requested to vote. Provision was made for handling emergency matters, whereby an emergency resolution could be introduced during the meeting of the House upon consent of two-thirds of the members. We believe this, while it may appear inconvenient to some, will prove of mutual benefit to all and should provide a more democratic means of conducting the business of our Association.

To further advance this spirit, the Council arranged for the agenda of Council meetings to be distributed to component society officers and delegates for their suggestions on matters they might desire brought to the attention of the Council.

Two important policy matters came before the Council. One was the establishment of the Indiana Medical Education Foundation, a trust fund, under the joint supervision of the Association and the Trustees of Indiana University. This fund was established for the purpose of receiving monies for the sole use of the Medical School in furthering education. At present nearly \$40,000 has been contributed by Indiana physicians for this purpose and it is hoped in years to come the fund will have grown to sizeable proportions.

The Board of Appeals on Physician-Patient Relations was strengthened by the House of Delegates and the Council was instructed to approve the rules of procedure for the board. This has been done and copies of the rules distributed to all members of the Association.

During the year, Mr. Robert J. Amick of Scottsburg was employed as field secretary for southern Indiana, in an effort to provide the best liaison possible between our Association and the component societies and between the societies themselves. Through this arrangement, Mr. Amick has been able to visit with a great degree of regularity the societies in his district and has made an effort to keep the membership informed. At the same time he has solicited suggestions for transmittal to the officials of our Association. It is planned to add another field man for the northern part of the state so that close liaison may be had with our entire membership.

The request of the Jefferson and Switzerland county medical societies was approved which permitted them to join and conduct their business under the name of the Jefferson-Switzerland County Medical Society.

WEMPLE DODDS, M.D., *Chairman.*

## REPORTS FROM DISTRICT COUNCILORS

### FIRST COUNCILOR DISTRICT

The year's activities in the First district have been many and varied. Relationship with the hospitals in the Evansville area has been greatly improved. Prominent activities have been radio speeches and recordings for improvement of public relations, the organization of a speakers bureau, assistance in Community Chest and The American Way.

The annual doctors, dentists and druggists picnic held in Evansville each year has gained nationwide publicity through Medical Economics. It has proved to be a great public relations event.

H. T. COMBS, M.D., *Councilor.*

### SECOND COUNCILOR DISTRICT

A few weeks prior to the Spring Council meeting your councilor called a meeting to discuss any district problems that officers of the district might want presented to the Council. Response was limited to officials from Daviess county and no business was transacted.

Your Councilor attended the regional meeting at Linton on March 20 and was more than pleased at the large attendance, the excellent food and fellowship, and the "grass roots" discussion of many medical problems that evolved so spontaneously during the course of the evening.

In accordance with the sound advice of E. J. McCormick, M.D., President-Elect of the A.M.A., for physicians to join and support organizations working for better understanding of Americanism and the exposure of socialism, your councilor presented a resolution at the Spring Council meeting for the purpose of endorsing the principles and objectives of the Association of American Physicians and Surgeons. After a short discussion by a small number of council members, that revealed their opinion that the A.M.A. was self sufficient in handling all problems of a socio-economic nature, the motion for endorsement was not passed.

At the interim meeting of the House of Delegates your councilor moved that Dr. Robert Rang be continued as alternate delegate to the A.M.A. That motion was carried.

Your councilor also entered into discussion at reference committee meetings on the question of unlimited expansion of Mutual Medical Insurance, expressing the stand that we should not plunge into all phases of coverage just because some were demanded by labor "leaders."

It should be reported that the host county for our District meeting in June had an excellent pro-



gram with good attendance, and that Doctor Ramsey introduced a resolution for a more widespread dissemination of truth and knowledge regarding the creeping socialism contained in Section 3 of H.R. 7800. Copies of the resolution were sent to the press.

A pre-council meeting of society officers was held near Shoals on July 10 with officers from Daviess, Martin, Knox, and Sullivan counties in attendance. The representatives from Sullivan county expressed the opinion that if the A.M.A. dues were to fluctuate from year to year, it would be better for the national office to bill and collect same, which might shorten the long time required for receipt of membership cards by members.

At the midsummer meeting of the Council your representative activated a motion to the effect that the executive committee of Blue Shield edit material appearing in the Blue Shield monthly bulletin called "Newsvane", because the July issue of that bulletin said: "The humbuggery of socialism and communism will never persuade our people to accept bureaucratic control of medical care. Only doctors can do that—if they fail to make rational adjustments of their services to the life and needs of our time." Such a socialist fallacy has no place in literature emanating from our insurance company. It is hoped that the editing committee will prevent further errors of this type.

The condition of the medical profession in all counties of the Second District appears to be normal, healthy and vigorous.

Your councilor will make every effort to sustain the traditional means of making I.S.M.A. policies correspond with those of its membership.

A. G. BLAZEY, M.D., *Councilor*

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### THIRD COUNCILOR DISTRICT

The Third District of Indiana Medical Association had its spring meeting at Bedford in May. It was well attended. Our President, Doctor Wright, met with us and gave a short report on I. S. M. A. The present Councilor was re-elected for another three years. French Lick was selected for the 1953 meeting place.

The hospital shortage is being well taken care of in our district. The new hospital at Salem is running at capacity and so is the one at Corydon. New Albany will open its Floyd County Memorial Hospital in the early spring.

It is my opinion that the Third District gives the public as fine a class of medicine and surgery and at as reasonable a cost as can be found in any district of Indiana.

WM. H. GARNER, M.D., *Councilor*

### FOURTH COUNCILOR DISTRICT

Nearly one hundred physicians and their wives attended the forty-eighth annual meeting of the fourth district, held at the Madison Country Club, Madison, on April 30, 1952.

The golfers teed off for their annual tournament at 9:00 a.m. with Robert O. Zink, M.D., Madison, crowned the best golfer of the day.

Following a Smörgåsbord luncheon, the members convened for their business meeting, and election of district officers. Dr. T. D. Carpenter, Columbus, was elected President; Dr. J. M. Black, Seymour, Vice-president; and Dr. H. E. Rothring, Columbus, Secretary-treasurer. The 1953 meeting will be held at Columbus.

The scientific program featured two papers; one by Dr. Glenn W. Irwin, of I. U. Medical School, on "Some Practical Aspects of Cortisone and ACTH Therapy." "Some Problems in Pediatric Urology" was the title of a paper given by Dr. Robert Garrett, of the Medical School.

The Auxiliary was entertained with a tour of the President's new home at Hanover College and a tea at the home of Dr. and Mrs. George May.

Guests introduced were: J. William Wright, M.D., Indianapolis, president, Indiana State Medical Association; Charles Overpeck, M.D., Greensburg, Councilor; Jas. A. Waggenger, executive secretary, and Robert Amick, field secretary.

CHAS. OVERPECK, M.D., *Councilor*

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### FIFTH COUNCILOR DISTRICT

The annual meeting of the Fifth District Medical Society was held at Greencastle in May. The business meeting and scientific sessions were held at the American Legion Hall. Following the meeting a cocktail party was enjoyed by the members, guests and we were joined by the Fifth District Medical Auxiliary. Dinner was served at the Old Trails Inn and was a gustatory success. Following dinner, the Society was enthralled by words of wisdom from the State Association's dignitaries.

There have been no unusual problems extant in the Fifth District during the past year. Copies of the agenda of each councilor meeting and of the Interim Session of the House of Delegates have been sent to all county officers prior to each meeting and a meeting of the county officers and delegates was held in Terre Haute prior to the Interim Session. This meeting was well attended and much help was obtained from it in furthering the business of the Session.

M. C. TOPPING, M.D., *Councilor*

### SIXTH COUNCILOR DISTRICT

The Sixth District has had an uneventful year, maintaining its usual excellent standard of professional work, good attendance by members and especially its well-knit political program. Members are kept informed of medical measures before the Congress and participate wholeheartedly in keeping alive a grass roots opposition to measures inimical to the welfare of the public and the profession.

We are fortunate in having a strong friend in Washington in our present Congressman, who goes far out of the way to keep us informed.

Every county in the district but one has a new hospital or a new addition. Henry county has one of the three approved cancer detection clinics and has been given a complete therapeutic X-ray setup, and now is to be recipient of a radium gift by the local Cancer Society.

The other public drives such as Red Cross, Crippled Children, Polio and Heart Disease are well supported, and in each county, are directed by members of the profession.

Public relations are at a high level because of emergency services, 24 hour coverage and cooperation with the Welfare Boards.

Rushville entertained the annual district meeting which was attended by the President-elect, Dr. Paul D. Crimm.

In accordance with the adopted plan the officers moved up, Dr. Harry Ross of Richmond assuming the presidency, Dr. R. D. Kuhn of Wilkinson, the vice-presidency and Dr. J. E. Fisher of New Castle was named the new secretary.

Dr. W. U. Kennedy was re-elected councilor.

W. U. KENNEDY, M.D., *Councilor*

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### SEVENTH COUNCILOR DISTRICT

During the past year, the Seventh Councilor district has had two fine meetings. The fall meeting was held at Martinsville on October 17, 1951. At this session, Dr. Ralph V. Everly, of Indianapolis, was elected president-elect; and Dr. Ray D. Miller, of Martinsville was chosen secretary-treasurer.

The Councilor was instructed to introduce before the October 1951 House of Delegates meeting a resolution calling for two meetings of the House of Delegates of the State Association. This was done and the first interim session of the House was held this year in April in Indianapolis.

A second resolution was passed that all members of the House of Delegates be informed 30 days in advance of resolutions which were to be considered by the House of Delegates, in order to provide more time for thought and consideration by the members of the House. This is now being done.

Following the above business and election of officers, a dinner and entertainment concluded the evening. Dr. Edward Pitkin, of Martinsville, the retiring president, relinquished the gavel to the incoming president, Dr. Wm. D. Province of Franklin.

On Jan. 7, 1952, a conference of the Seventh district societies' officers and the Councilor was held at Indianapolis for the purpose of discussing the agenda for the next meeting of the Council of the State society. All of the four counties of the Seventh district were represented. Considerable discussion was held on proposals to improve the appeal of the annual state conventions. Majority opinion seemed to favor return to the Section meetings instead of general scientific sessions; and the reduction of the number of scientific speeches. The Seventh district felt that the conference was highly desirable, but should be maintained on a voluntary basis.

The Spring meeting of the Seventh district was held in Indianapolis, May 13, 1952. Doctor Province presided. At this meeting, a resolution was adopted unanimously opposing federal aid to public school education. Mr. Converse, of Mutual Medical, Inc., gave a brief report on the company. The address of the evening was given by the Rev. Granger Westberg, chaplain of Chicago's Augustana Hospital on the co-operation of the physician and the minister.

This Councilor wishes to take this opportunity to thank all the officers and members of the Seventh district for their fine co-operation during the past year.

ROY A. GEIDER, M.D., *Councilor*

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### EIGHTH COUNCIL OR DISTRICT

The Eighth District Medical Society held its annual meeting May 21, 1952 at the Anderson Country Club.

The afternoon program included golf, cards and general social intercourse.

After a delicious evening meal, Dr. B. T. Horton of the Mayo Clinic delivered an address on "Histamine Cephalalgia." The address was well demonstrated by very dramatic motion pictures.

Your councilor reports with regret that there was no representative of the Indiana State Headquarters' office and no representation from Jay or Radolph County Medical Societies.

The date for the Eighth district meeting has tentatively been set for May 21, 1953 at the Delaware Country Club.

T. R. HAYES, M.D., *Alternate Councilor*.



### NINTH COUNCILOR DISTRICT

During the past year the component societies of our district have been active in improving public relations and medical services to our citizens. Our physicians are assuming an increasingly important role in community activities and are coming to realize that they can be of inestimable value in guiding the lay health groups and furnishing sound advice from a professional standpoint. With these lay organizations assuming an increasingly important role, it is vitally important for doctors to assist these organizations in every way possible. County Health Councils particularly need the active participation of physicians and it is gratifying to note that our members are participating in these community activities.

The telephone postgraduate seminars have, for the most part, been well received and several of the societies have been using the seminars in lieu of obtaining scientific speakers.

The annual meeting was held at Crawfordsville on May 21. A golf tournament was held in the morning and the afternoon was devoted to a scientific program. Speakers were Dr. Lyman T. Meiks of Indianapolis, Dr. R. B. Turnbull, Jr. of Cleveland and Drs. L. G. Montgomery, William Sneed, Jr., and William B. Adams of Muncie. Speakers at the evening banquet were Louis Bromfield, author and lecturer of Lucas, Ohio, Dr. J. William Wright, president of the Indiana State Medical Association, and James A. Waggener, executive secretary of the Indiana State Medical Association. The present councilor was re-elected for a period of three years.

Two pre-council meetings of the officers of the county societies were held at Lafayette. Attendance was somewhat disappointing, but those attending the meetings expressed enthusiasm and thought that they were very valuable.

WEMPLE DODDS, M.D., *Councilor*

### TENTH COUNCILOR DISTRICT

The past year has been an unusually active one for the Tenth district.

On October 10, 1951, a dinner attended by 110 members was held in Whiting. At this meeting Dr. Hugh Kuhn of Hammond was elected president and Dr. Lee Hickman of Hammond elected secretary.

Dr. Albert Dorfman of the Bobs Roberts Memorial Hospital, University of Chicago discussed the uses and contra-indications for the drugs Cortisone and ACTH.

The problems of physicians with the income tax matters was discussed by the Deputy Collector, Bureau of Internal Revenue, Mr. William Dittrick.

April 17 the Spring district meeting was held in Whiting and 104 physicians attended.

The meeting was addressed by Dr. Denton Kerr of Houston, Texas, who warned of creeping socialism throughout America.

Dr. J. William Wright, President of the Indiana State Medical Association was able to attend this meeting and briefly addressed the group.

June 10 the district golf parties, discontinued during the war, were revived with a golf tournament and dinner at the Hazeldon Country Club, Brook, Indiana, formerly the home of George Ade. Perfect weather brought a good turnout for this party. Several of the members who had known George Ade were reminiscent of former parties here and of his writings and plays.

W. H. HOWARD, M.D., *Councilor*

### ELEVENTH COUNCILOR DISTRICT

The fall meeting of 1951 was held at the Honeywell Memorial Center in Wabash, Sept. 19, 1951. It was well attended, and the program was good, consisting of a paper on "Skull Fractures and Brain Injuries" by Harry E. Mock, M.D., Chicago, and one by Wallace E. Bash, M.D., Ft. Wayne, on "Care of the Premature". The evening talk was by John M. Kelley, Jr., former U.S. attorney.

The spring meeting, 1952, was held in Kokomo at the Y.W.C.A. on Wednesday, May 21. The program was as follows: "Headache" by Dr. Stuyvesant Butler of Chicago and "The Surgical Aspect of Mitral Stenosis" by Dr. Mason Sones and Dr. Donald Effler of Cleveland, O. The evening speaker was Mr. Eugene C. Pulliam, editor of the Indianapolis Star and News.

We have now held four of the pre-Council meetings with the officers of the component societies, at Kokomo in September, Peru in January, Marion in April, where we were invited to sit in at the regular monthly medical meeting of the Grant County society, and at the C. and C. Beach on Lake Freeman in Carroll county in July. Although these meetings are optional with the Councilors this year, we feel that they have been very helpful and worth continuing.

Detailed reports of the several counties follow:

**Carroll County**—(10 active; 1 senior member).

Dr. John R. Wagoner, formerly of Colburn, has opened an office in Delphi.

**Cass County**—(36 members—31 active; 5 senior).

Dr. Edgar W. Killian, graduate of Loyola University School of Medicine and his wife, Dr. Camille Hill Killian, a graduate of the University of Illinois School of Medicine, have begun an ophthalmological and otolaryngological practice in Logansport.

Dr. J. C. Travis of Indianapolis is taking a

residency in psychiatry in the Logansport State Hospital.

Clayton C. Campbell, M.D., 72, formerly of Walton, died in Long Beach, California, on November 22, 1951. He was a graduate of the Central College of Physicians and Surgeons at Indianapolis in 1904.

Dr. W. W. Holmes is President-Elect of the State Academy of Ophthalmology and Otolaryngology.

Dr. Thomas E. Slimp has begun the practice of medicine in Logansport. He is a graduate of Syracuse University College of Medicine in New York. He has been in the U. S. Navy for six and one-half years.

**Grant County.** (48 members).

Dr. Frederick H. Simmons of Marion, formerly with the V.A. Hospital in Marion, has returned to private practice.

Dr. Alvin F. Wiersma, a graduate of the University of Michigan School of Medicine, has become associated with the Davis Clinic in Marion as supervisor of the department of obstetrics and gynecology.

Dr. Charles Yale, a native of Fairmount, has entered the practice of medicine in Winamac.

**Howard County.** (43 active, 3 senior, 2 retired or disabled former members).

Dr. Reuben Craig has entered the practice of pediatrics with his father, Dr. R. A. Craig, in Kokomo. Dr. Craig is a graduate of the University of Louisville School of Medicine.

Dr. Guy Morford, anesthesiologist of Kokomo, has moved to Owensboro, Ky., where he will practice his specialty. Dr. Morford has been very active in hospital and organizational work during his brief time of practice in Kokomo, being first vice-president of the Howard County Medical Society at the time of his departure.

Dr. C. C. Bowers of Kokomo was elected president of the Howard County Scottish Rite club.

Dr. Carl H. Ault has recently entered general practice in Kokomo. He is a graduate of Indiana University School of Medicine, 1950 and served in the U. S. Air Force.

The Howard County Medical Society has completed its first full year's trial of the Executive Council plan, which facilitates the transaction of business without sacrificing democratic principles and ideals.

**Huntington County.** (22 active members).

**Miami County.** (19 active, 2 senior members).

Dr. Donn Hunter, formerly of Converse, has moved to Greenfield to engage in the general practice of medicine.

The Miami County society has as one of its projects the vaccination of the entire school city of Peru.

**Wabash County.** (18 active, 5 senior members).

A native of North Manchester, Dr. E. Everett Lefforge, recently opened an office in Veedersburg, Ind.

ELTON R. CLARKE, M.D., *Councilor*.

## TWELFTH COUNCILOR DISTRICT

The Twelfth District Society held its annual meeting on May 27, 1952 at the Fort Wayne Chamber of Commerce.

In the afternoon meeting Walter J. Reich, M.D., Cook County Post-graduate School of Medicine, Chicago, spoke on the "Diagnosis and Treatment of Gynecological Bleeding."

The Twelfth District Auxiliary meeting was held in the Y.W.C.A. and at 6:30 p.m. they joined the doctors in a dinner meeting. After dinner speaker was Senator Homer E. Capehart.

The following officers were elected during the afternoon session: Edward H. Schlegel, M.D., President; James M. Burk, M.D., Vice-President; M. L. Habegger, M.D., Secretary; M. B. Catlett, M.D., Councilor, and Otto F. C. Lehmberg, M.D., Alternate Councilor.

The new Parkview Memorial Hospital is about 35 percent completed. An additional \$2,700,000 was raised this year in Fort Wayne and Allen County by subscription. This money will be used for an addition to the Fort Wayne Lutheran Hospital and to complete the Parkview Memorial.

M. B. CATLETT, M.D., *Councilor*

## THIRTEENTH COUNCILOR DISTRICT

The County Medical Societies comprising the Thirteenth Medical District of the Indiana State Medical Association have been active in improving and extending coverage of medical service to the people. The past year a new hospital has been opened at Knox, and construction has been started on an addition to the Elkhart General Hospital. Plans are in various stages of completion for building additional hospital beds in other cities and towns. The most acute shortage of beds is now at South Bend and plans are being formulated for the raising of money to build more hospital beds.

The annual meeting was held in South Bend on November 14, 1951. The meeting began at 10:00 a.m. at the South Bend Medical Foundation. The first paper was given by Jene R. Bennett, M.D., on "Recent Progress in Rh Factor Studies" followed by a paper given by Carl S. Culbertson, M.D., on "Recent Progress in Diagnoses and Treatment of Hemolytic Syndromes." At a luncheon meeting our Indiana State Medical Association President J. William Wright, M.D., gave an excellent talk. James Waggener, the Executive Secretary of the



State Medical Association, also attended our meeting.

Following the luncheon a business meeting was held at which the following 1952 officers were elected: President—Floyd S. Martin, M.D., Goshen; Vice-President—John E. Luzadder, M.D., New Carlisle; Secretary-Treasurer—O. E. Wilson, M.D., Elkhart. The councilor and alternate councilor terms expire in 1953 and 1952 respectively.

In the afternoon the scientific program continued with the following program:

1. "Pardon Me! Your Skin Is Showing," James R. Webster, M.D., Chicago.
2. "Progressive Steps in Geriatrics," William I. King, M.D., Indianapolis.
3. "Differential Diagnosis of Spinal Cord Lesions," Paul Bucy, M.D., Chicago.

The auxiliary of the Thirteenth District Medical Association met for luncheon and an afternoon meeting.

The wives joined the doctors for dinner. The after dinner speaker was Thomas A. Hendricks of the American Medical Association who gave an excellent and entertaining talk as usual. The title of his talk was, "Merry-Go-Round of Medical Care."

KENNETH L. OLSON, M.D., *Councilor*.

## EXECUTIVE COMMITTEE

The Executive Committee has met regularly every month since the last meeting of the House of Delegates. The volume of work that has come before the committee has been large and has required long hours of deliberation and study before decisions were made. Those matters that could be delayed for action until the Council met were so delayed, while those matters requiring immediate attention of the committee were later reported to the Council for concurrence and approval.

Inasmuch as the minutes of the meetings of the committee have been published in issues of the Journal preceding this, we will not review at this time the actions of the committee in detail. However, copies of the minutes will be supplied to each member of the reference committee for his information and study.

The year was marked with many activities which we believe you will agree were of great magnitude. One point which we feel we should emphasize in this report is the comprehensive study made by the committee of the operation of our association. It was revealing to us to find the great amount of detail work carried on by our headquarters staff, and the many demands placed upon their time. It was also almost unbelievable to learn of the tremendous volume of mail which emanates from our

Association offices. We believe our association has accomplished more during the last year to keep our membership fully informed on subjects of importance and medical economics than at any time in the past.

Certain changes in operational procedures will be noted as time progresses. The first important change will be placed into operation the first of the year when a new system of records for handling membership will be installed. This new system was adopted by your committee after careful study and upon finding that the new system should greatly reduce the work-time of the component society secretary as well as the headquarters staff. Other improvements in our operation are under study and we hope in time many of our procedures may be streamlined so as to make our association function with greater effectiveness and more efficiency.

The committee would like to call to the attention of the membership generally, that it is hopeful the component societies will avail themselves of the opportunity to learn more about our association and its programs as the activities of organized medicine are being stepped up to a greater tempo than at any time in our history. The problems facing medicine have been multiplying at every level, and only through complete understanding and cooperation among ourselves, may we present the united front so necessary on the part of organized medicine today.

## THE JOURNAL

Mechanical improvements and an on-trial feature have attracted attention of JOURNAL readers during the last year. An editorial secretary and an employee to schedule advertising and keep records have handled the full office routine of THE JOURNAL.

Since August, 1951 only three special issues of THE JOURNAL have been published. In October the annual Convention issue was the first of the special numbers; April was devoted to Cancer and the July issue was the regularly planned Medical Yearbook, containing the full membership roster and much auxiliary information.

## Advertising

Survey of advertising for the first six months of 1952 discloses a small increase over the corresponding period of 1951. With a substantial increase indicated for the rest of the year, THE JOURNAL advertising is expected to exceed last year's volume.

Figures on advertising for the first six months of the last three years, compared to the first six months of 1952 follow:

First Six Months	1949	1950	1951	1952
From A.M.A.				
agency ---	\$ 8,133.26	\$ 7,836.86	\$ 9,070.88	\$ 8,134.65
Direct to				
Journal ---	4,564.23	4,467.31	3,813.82	5,027.65
Total ---	\$12,697.49	\$12,304.17	\$12,884.70	\$13,162.30

### Printing Costs

Cost of printing THE JOURNAL during 1951 and the first six months of 1952 continues to show a slight decline as indicated in the following table covering the last five-year period. Costs are in relation to total number of pages.

Year	Cost	Number of Pages (Inserts Excluded)
1947 -----	\$24,790.34	1,462
1948 -----	\$26,391.00	1,380
1949 -----	\$28,572.41	1,360
1950 -----	\$24,664.07	1,324
1951 -----	\$23,735.75	1,304
1952 (6 months) -----	\$11,072.83	614

The following table shows the number of Journal pages for the last six years and indicates percentages of reading and advertising material in relation to the totals.

Year	Read- ing	Per Cent Read- ing	Adv. Pages	Per Cent Adv.	Total Pages	Avg. Pages Per Issue
1946 -----	696	46	824	54	1520	126.7
1947 -----	681	45	837	55	1518	126.5
1948 -----	703	49	707	51	1410	117.5
1949 -----	740	53	652	47	1546*	262.0
1950 -----	690	51	664	49	1354	112.8
1951 -----	674	50*	660	49*	1334	111.1

\* Includes 172 pages of "One Hundred Years of Indiana Medicine."

### MEDICAL DEFENSE ACTIVITIES

1. *Malpractice cases.* A year ago, at the time of this report, August 1, 1951, the following twelve cases were pending before the committee, two of which were closed during the year, leaving ten cases still pending.

Case No. 200—Filed February 12, 1932. Pending.

Case No. 251—Filed September 25, 1942. Pending.

Case No. 255—Filed September, 1945. Awaiting assignment for trial.

Case No. 268—Filed September 7, 1948. Pending.

Case No. 269—Filed September 28, 1949. Pending.

Case No. 270—Filed September 28, 1949. Pending.

Case No. 271—Filed September 16, 1949. Pending on change of venue.

Case No. 272—(Closed). Filed against three physicians December 27, 1949. Expense \$700.00, paid February 29, 1952. Dismissed December 27, 1951.

Case No. 273—Suit not yet filed. Effort being made to obtain settlement.

Case No. 274—Suit filed May 25, 1951. Pending.

Case No. 275—(Closed). Suit filed September, 1950. Settled for \$2,000.00 with approval of defendant, September, 1951. Expense, \$200.00, paid November 26, 1951.

Case No. 276—Filed April 11, 1951. Pending.

Since August 1, 1951, and up to August 1, 1952, the following five new cases have come before the committee, two of which have been closed, making a total of thirteen cases pending at the present

time as against twelve unclosed cases at the same time last year:

Case No. 277—(Closed). Filed November 15, 1951.

Dismissed March 14, 1952. Expense, \$310.00, paid May 8, 1952.

Case No. 278—(Closed). Case compromised and settled without being filed, March, 1952. Expense, \$100.00, paid May 8, 1952.

Case No. 279—Filed May 19, 1952. Pending.

Case No. 280—Filed March 11, 1948. Trial court directed verdict for the defendant; plaintiff took an appeal to Appellate Court, petition for transfer to Supreme Court now in preparation. Expense to date, \$365.00\*, paid August 8, 1952. \*(Not included in disbursements below).

Case No. 281—Filed May 20, 1952. Pending.

### 2. Medical Defense Fund Statement, from August 1, 1951, to August 1, 1952:

Balance, August 1, 1951 ----- \$4,548.96

#### Receipts:

Dues, 4—1950 members-----	\$ 5.00	
160—1951 members-----	200.00	
3,318—1952 members-----	4,147.50	4,352.50
Interest on bonds -----	440.00	4,792.50
		<hr/>
		\$9,341.46

#### Disbursements:

*Malpractice fees -----	\$1,310.00	
Salary of Association attorney --	1,845.00	
Treasurer's bond -----	37.50	
Purchase of U. S. Savings Bonds--	1,000.00	
Traveling and telephone expense--	55.65	4,248.15
		<hr/>

Balance in Medical Defense Fund checking account, August 1, 1952 ----- \$5,093.31

C. J. CLARK, M.D., *Chairman.*

W. L. PORTEUS, M.D.

J. WILLIAM WRIGHT, M.D.

PAUL D. CRIMM, M.D.

ROY V. MYERS, M.D.

WEMPLE DODDS, M.D.

## BOARD OF APPEALS ON PATIENT-PHYSICIAN RELATIONS

The new Board of Appeals on Patient-Physician Relations, authorized by the 1951 regular session of the House of Delegates and amended to the by-laws as a standing committee of the Association was organized on call of President Wright February 3, 1952.

The Board has spent considerable time in studying and formulating rules and methods of procedure for processing complaints. These were



approved unanimously by the Council, April 26, 1952. They have been published in the JOURNAL, printed in booklet form, and copies were sent to every member of the Association.

The Board has held six meetings and received and considered 18 complaints to date.

A majority of the complaints received have been amicably adjusted to the satisfaction of both patient and physician. Final action on several complaints await reports from county medical societies or physicians. Complaints received after the case has been placed in the hands of an attorney or filed in court are not accepted for adjustment by the Board. No complaints received to date have been referred to the Council for disciplinary or legal action.

With a few exceptions, the Board has received excellent cooperation from complainants, physicians, and county medical societies.

The Board wishes to commend the President, Executive Secretary, and the Legal Councilor of the Association for their valued assistance and cooperation. These three officials have attended and participated in all the meetings of the Board.

It is the opinion of this Board that the authority granted by the House of Delegates, and the rules and methods of procedure approved by the Council adequately provide for:

1. Fair and impartial consideration of aggrieved patient's complaints.
2. Protection of the physician against imposition.
3. Maintenance of the prerogative of the physician and the county medical society to keep their own houses in order.
4. Improved public relations, confidence and respect for the medical profession.
5. Disciplinary action by the Council for those few who violate their professional responsibilities or exploit the public.

The Board believes that the few complaints received indicate that adequate, ethical, and satisfactory medical care prevails in Indiana. We, therefore, recommend that the Board of Appeals on Patient-Physician Relations be continued without change in rules, authority, or methods of procedure.

AUGUSTUS P. HAUSS, M.D., *Chairman*  
 CLAUDE S. BLACK, M.D., *Vice-Chairman*  
 C. M. JONES, M.D., *Secretary*  
 A. M. MITCHELL, M.D.  
 LLOYD MARSHALL, M.D.  
 JOHN C. CARNEY, M.D.  
 WM. C. REED, M.D.  
 HARRY P. ROSS, M.D.  
 CARL H. MCCASKEY, M.D.

## COMMITTEE ON CONFERENCE OF COUNTY MEDICAL SOCIETY OFFICERS

Your committee desires to report a very successful annual conference was held in Indianapolis on Sunday, March 2, 1952. Attendance for the meeting totaled 125, and from all reports received by your committee the meeting was successful in all respects.

For your information and for the record we list here the program of the 1952 meeting:

Welcome and Orientation of those in attendance—J. William Wright, M.D., President, Indiana State Medical Association; How We Set Up Our Civil Defense Program—John E. Lamb, Director, Vigo County Civil Defense Council; discussants: E. Vernon Hahn, M.D., Indianapolis, C. D. Holmes, M.D., Frankfort; group discussions—Summary—L. E. Burney, M.D., State Health Commissioner; Campaign Against Socialism—E. J. McCormick, M.D., Toledo, Ohio, member of the Board of Trustees of the American Medical Association and President-elect of the American Medical Association; discussants: James L. Doenges, M.D., Anderson; Lall G. Montgomery, M.D., Muncie; group discussion.

Address by R. A. Kern, M.D., Philadelphia, Professor of medicine, Temple University and Secretary-General of the American College of Physicians; Your Public Relations Is Showing—John R. Allen, Indiana State Teachers College, Terre Haute; discussants: Robert K. Webster, M.D., Brazil; David D. Oak, M.D., LaCrosse, Indiana's first family Doctor of the Year; group discussion; Your State Office and the AMA—Paul D. Crimm, M.D., Evansville, President-elect, Indiana State Medical Association; discussants: Earl W. Mericle, M.D., Indianapolis; Leo Brown, Chicago, Public Relations Director of the AMA; group discussion.

Perhaps the one feature of this meeting which proved so popular with those in attendance was the open discussion periods in which all in attendance had the opportunity of joining. This seemed to mark the first time those in attendance had the opportunity to participate in the program, and we cannot recommend too strongly to the committee in charge of future programs that they, too, arrange their program so those in attendance may take an active part in the various discussions.

RALPH R. PLOUGHE, M.D., *Chairman*  
 FRANK W. MESSER, M.D.  
 HUGH S. RAMSEY, M.D.  
 CLAUDE D. HOLMES, SR., M.D.  
 LALL G. MONTGOMERY, M.D.  
 JAMES P. GILLIATT, M.D.

## COMMITTEE ON CONSTITUTION AND BY-LAWS

As of this date, there have been no meetings of the Committee on Constitution and By-Laws.

JOHN H. GREEN, M.D., *Chairman*  
A. M. MITCHELL, M.D.  
A. A. THOMPSON, M.D.  
PAUL R. TINDALL, M.D.  
DONALD G. MASON, M.D.

also the Council of the Indiana State Medical Association and the editor of THE JOURNAL for their fine cooperation.

E. S. JONES, M.D., *Chairman*  
RICHARD C. SWAN, M.D.  
JOHN W. HILBERT, M.D.  
LOUIS W. SPOLYAR, M.D.  
EMMETT B. LAMB, M.D.  
ALLAN K. HARCOURT, M.D.

## COMMITTEE ON INDUSTRIAL HEALTH

The Committee on Industrial Health of the Indiana State Medical Association submits the following report for the year, 1952:

"Medical Directives for the Nurse in Industry" has been completed and was published in the February, 1952, issue of THE JOURNAL of the Indiana State Medical Association. Reprints have been sent to nurses in industry throughout Indiana. They have also been mailed to various individuals, plants and organizations throughout the United States, Alaska and Hawaii. The comments have been very flattering.

A subcommittee of the Committee on Industrial Health composed of Dr. Lamb, Dr. Spolyar and Dr. Harcourt, spent many hours and a great deal of thought, formulating the instructions. They were reviewed many times by the full committee; also by the Industrial Nurses' Section of the Indiana State Nurses' Association, by Dr. Peterson and Dr. McCahan of the American Medical Association, as well as by various doctors in industry throughout the United States. All submitted suggestions which were considered and incorporated in the "Directives" where indicated. No directive can cover every emergency. However, this is a workable pamphlet which we believe can be of great help to nurses in industry, and possibly to plant physicians as well.

"Compensation Schedule for Particular Results of Injuries" to help the busy doctor determine quickly permanent impairment percentages in certain specific losses was published in THE JOURNAL. It is also available in leaflet form and may be secured from the Chairman named below. It can be used as a desk reference to figure readily the loss of each finger or toe and also the hand or foot as a whole. Other specific losses as stated in the compensation laws of Indiana have been included.

Other matters were given consideration by the Committee but the above are its major accomplishments for this year.

The chairman wishes to thank every member of the Committee for his time and earnest efforts;

## COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

The Committee on Medical Education and Hospitals has completed a very eventful and busy year. We are of the opinion that much has been accomplished and that our efforts have focused favorable attention upon our state and our medical association. We have been active in three different areas during the year, namely postgraduate education via telephone, recorded loan library and the Medical Education Foundation. We shall endeavor to explain our work in these areas as follows:

### Telephone Seminars

We have completed our second successful year in handling postgraduate education through the medium of the telephone. It is our belief that these programs have been received with favor by a large segment of our membership. We are happy to report again that our operation has been self-sustaining, and it has not been necessary to call upon the association for funds to carry on these activities.

Since the last annual meeting of the association, we have conducted eight telephone seminars on the following subjects:

October 2, 1951—Treatment of Hyperthyroidism.  
November 6, 1951—Acute Surgical Emergencies.  
December 4, 1951—The Newer Aspects of the Diagnosis and Treatment of Tuberculosis.  
January 8, 1952—Medical Emergencies.  
February 5, 1952—Heart Roundtable.  
March 4, 1952—Care of the Infant—First Year.  
April 1, 1952—Seminar on Malignancy.  
May 6, 1952—Recent Trends in Cesarean Section—Symposium.

Our efforts in this field have gained national attention. We are happy to report that the states of Texas and Kentucky have followed our lead and have instituted a series of postgraduate programs via telephone. Our service was publicized in a nationwide radio program conducted by the American Medical Association, and we have received much national publicity on this service. Inquiries have



been received from practically every state in the Union and from the territory of Hawaii seeking information as to how we went about conducting our telephone and recorded postgraduate programs.

We realize this system is not the final answer, but we hope through the continued cooperation and suggestions of our many county medical societies, we shall continue to perfect our programs to the point where our entire membership will enthusiastically endorse this effort of your committee.

### Recorded Programs

It soon became evident if we were to fulfill the need of our many societies who could not arrange their meetings on the same night as our telephone broadcasts, that we must offer our programs through the medium of wire recordings. So successful was this venture, and so acceptable was this method of transmission of our program, we embarked upon another experiment of recording lectures of outstanding authorities throughout the nation on pertinent medical subjects, these to be offered to our societies and our individual members on a loan basis. The first list of recordings in our library was announced May 1, and the second list was announced July 1. The response to this offering has exceeded our fondest expectations. Members, as well as societies have been quick to avail themselves of this service, which has been supplied at no cost to the society or the member. Since last year, we have added a tape recorder to our equipment and we are now offering these recordings on either wire or tape.

We were successful this year in gaining approval of the American Medical Association to record the scientific portion of the Annual Session program, which in turn could be loaned to our membership. Through this effort, we have interested the Council on Scientific Assembly of the AMA in the project of recording the scientific papers at their annual and clinical session the same to be made available to the various states for distribution to their membership or component county societies. We might add this marks the first time, scientific papers given at the AMA have been recorded, and Indiana has received the honor of being designated as the state to test this plan, before adoption by the AMA. We list herewith the recorded lectures which have been made available to our members and our societies:

1. Prognosis in Coronary Disease, Roy W. Scott, M.D., Cleveland.
2. Management of the Arrhythmias, Thomas J. Dry, M.D., Rochester.
3. Some Aspects of the Diagnosis and Treatment of Vascular Disease, Edgar A. Hines, Jr., M.D., Rochester.
4. Medical Management of Hypertension, Robert A. Wilkins, M.D., Boston.
5. Changing Concepts and Techniques in the Management of Heart Failure, Charles K. Friedberg, M.D., New York.
6. The Relationship Between the Histologic Types of Breast Cancer and Prognosis, L. V. Ackerman, M.D., St. Louis.
7. Does Carcinoma Arise in Pre-existing Benign Lesions of the Breast, Shields Warren, M.D., Washington.
8. How to Manage Chronic Cystic Mastitis, Murray M. Copeland, M.D., Washington, D. C.
9. The Diagnosis of Breast Cancer—Early and Late, Eugene M. Bricker, M.D., St. Louis.
10. When Is Carcinoma of the Breast Operable?, Cushman D. Haagensen, M.D., New York.
11. Radical Mastectomy—Its Criteria and Uses, Grantley W. Taylor, M.D., Boston.
12. The Use of Radiation Therapy in Breast Cancer, U. V. Portmann, M.D., Cleveland.
13. The Office Management of Advanced Breast Cancer, Ira T. Nathenson, M.D., Boston.
14. Office Gynecology, Sprague Gardiner, M.D., Indianapolis.
15. Counseling on Family Relations, Evelyn Duvall, Ph.D., Chicago.
16. The Irritable Colon, C. Wilmer Wirts, M.D., Philadelphia.
17. Diagnosis and Treatment of Acute Toxic Nephrosis, Francis D. Murphy, M.D., Milwaukee.
18. Management of Hypertension, Edward Freis, M.D., Washington.
19. Cardiac Emergencies, Tinsley Harrison, M.D., Birmingham, Ala.
20. Therapeutic Panel:  
ACTH and Cortisone, Glen W. Irwin, M.D., Indianapolis.  
Resins, B. L. Marts, M.D., Indianapolis.  
New Drugs, Don Wolfram, M.D., Indianapolis.  
Treatment of Peptic Ulcer with New Drugs, Bernard Rosenak, M.D., Indianapolis.
21. Treatment of Coronary Heart, W. D. Stroud, M.D., Philadelphia.
22. Pelvic Malignancies, Charles W. Hendricks, M.D., Columbus, Ohio.
23. Treatment and Management of Burns, W. H. Steffen-son, M.D., Grand Rapids.
24. The Management of the Arteriosclerotic, Wm. A. Thomas, M.D., Chicago.
25. Your Feet and Mine, Gordon W. Batman, M.D., Indianapolis.
26. Pathological Conference: Mechanism of Loss of Consciousness and Its Management, Edgar A. Kahan, M.D., Ann Arbor.
27. Proctology, Louis Hirschman, M.D., Detroit.
28. Recent Trends in Gallbladder Surgery, Warren H. Cole, M.D., Chicago.
29. Benign Lesions of the Breast Which May Be Mistaken for Carcinoma, C. D. Haagensen, M.D., New York.
30. Surgery of the Pancreas, Richard B. Cattell, M.D., Boston.
31. Carcinoma of the Stomach, Alton Ochsner, M.D., New Orleans.
32. Development of Therapy in Tropical Medicine, L. T. Coggeshall, M.D., Chicago.
33. Intermediary Metabolism, Sidney Weinhouse, M.D., Philadelphia.
34. The Nature of the Peptic Ulcer Problem, C. T. Stone, M.D., Galveston, Texas.
35. Benign Gastric Mucosal Prolapse Into Duodenum, Jacob Lichstein, M.D., and Leonard M. Asher, M.D., Los Angeles.
36. Adenomatous Polyps of the Colon and Rectum, Alejandro F. Castro, M.D., Washington, D. C.
37. Sigmoidoscopy: An Analysis of 3,500 Consecutive Cases, Paul L. Shallenberger, M.D., and Peter Fisher, M.D., Sayre, Pennsylvania.

38. Present Status of ACTH and Cortisone, Willard O. Thompson, M.D., Chicago.
39. The Place of Cortisone in the Treatment of Rheumatoid Arthritis, Emerson Ward, M.D., Philip S. Hench, M.D., Charles H. Slocumb, M.D., and Howard F. Polley, M.D., Rochester, Minnesota.
40. Billings Lecture: Focal Infection: Status After Forty Years, George H. Coleman, M.D., Chicago.
41. The Treatment of Diffuse Progressive Scleroderma, James A. Evans, M.D., Boston; Hyman J. Rubitsky, M.D., Roxbury, Mass., and Albert W. Perry, M.D., Victoria, B. C., Canada.
42. Psychosomatic Disorders and the Non-Psychiatrist, Bernard I. Lewis, M.D., Iowa City.
43. The Management of Sexual Conflicts in General Practice, Wilfred C. Hulse, M.D., New York.
44. Management of Osteoarthritis in the Aged, John G. Kuhns, M.D., Boston.
45. Intractable Duodenal Ulcer, Sidney A. Portis, M.D., and Charles H. Lawrence, M.D., Chicago.
46. Newer Concepts in the Use of ACTH and Cortisone in Clinical Practice, Laurence W. Kinsell, M.D., Oakland, California.
47. Practical Aspects of Inguinal Hernia, Philip Thorek, M.D., Chicago.
48. The Complications and Sequelae of Acute Myocardial Infarction, A. Carlton Ernestene, M.D., Cleveland.
49. An Evaluation of New Anticoagulants, Irving S. Wright, M.D., New York.

### Medical Education Foundation

As you well recall, this House of Delegates, just one year ago accepted the challenge of formulating a campaign to raise funds for our financially embarrassed medical schools. Just one year ago, this committee called to your attention the request of the AMA that assistance was sorely needed if the nation's centers of medical education were to continue to operate as free institutions, free of government control through government subsidy. You so willingly responded with over \$8,000 in pledges and authorized us to place into operation a program to raise, through voluntary effort, a sum of \$100,000, which would represent our effort to help our medical schools to continue to operate as free institutions.

We are proud to report that Indiana in 1952 leads all states in this nation for funds sent to the American Medical Association for this purpose. Many states have found it necessary to levy assessments in order to make a showing toward this effort. Indiana, on a strictly voluntary program and through a vigorous campaign of education has sent more than \$48,000 in cash to the AMA during the period of January 1, 1952 to July 15, 1952. While we may take pride in this achievement, nevertheless, we should feel ashamed that such a small percentage of our membership has made this achievement possible. In order to attain this record, less than one-fifth of our membership has made a contribution. If everyone of our members would carry their fair share of the load, we could have attained our goal much earlier.

Realizing this effort was just not for this year, but that it must be continued if the purpose of the campaign was to be achieved, your committee suggested that our membership make pledges covering a period of three years. We then realized, that

inasmuch as many of the members of the association would perhaps favor making contributions to their Alma Mater, Indiana University, we sought permission of the Council for the establishment of a Trust Fund to be known as the Indiana Medical Education Foundation—this trust to be set up under joint supervision of the Trustees of Indiana University and your association in such a way as to be enabled to receive gifts and estates left for the purpose of making our state university one of the strongest and best in the nation. Too, since our state school is tax-supported and since there might be times when our gifts would become involved with regular state funds, we felt it a safeguard to establish a separate fund for the purpose of receiving these gifts, so that they might always be in readiness in case of need.

We are happy to report that this trust has been approved by the Board of Trustees of Indiana University and the Council of this Association, and the first deposit has been made to the trust in the amount of \$37,462.97. The depository has been established with the Fletcher Trust Company, and the money collected will be spent under the supervision of your association and the University.

Our committee wishes to thank each of the contributors to the fund and hopes you will use your influence with your colleagues so that we will have a 100 percent contribution from our members. Such action will assure success.

JAMES W. DENNY, M.D., *Chairman*  
 HARRY P. ROSS, M.D.  
 MAURICE E. GLOCK, M.D.  
 WILLIAM C. REED, M.D.  
 DURWARD W. PARIS, M.D.  
 HARRY KLEPINGER, M.D.

### COMMITTEE ON PUBLIC POLICY AND LEGISLATION

Your committee has devoted its energies during the past year to preparing for the coming session of the State Legislature, and in keeping informed on national legislative matters. We have kept the Council informed of events and have had their support in carrying on many of our activities. Not only has the year been spent planning for the 1953 session of the State Legislature, but we have also made an effort to increase the knowledge of our membership on legislative matters through the addition of the pink section to our state JOURNAL. This section reviews legislative matters concerning medicine, and from comments received, is serving a very useful purpose.

The request of the Committee was approved to try for a limited time the inclusion of a section in THE JOURNAL devoted exclusively to legislative matters. It was the intent of the committee to use this method of keeping the membership posted on pertinent facts concerning legislation. So favorable has been the response of the membership to this feature the committee recommends that it be made a permanent part of THE JOURNAL.



In reviewing matters that are to come before the coming session of the State Legislature, the committee would like to call to the attention of the membership the following:

The chiropractors will again make a strong effort to have a bill passed establishing their own board. They have been active since the close of the 1951 session, organizing what is known as "Layman Chiropractic Associations" made up of their patients and friends. They will depend upon this organization to do much of their fighting for them during the legislature. They are also counting on these individuals to contact the members of the legislature in their local communities for the purpose of putting pressure on them to vote for the chiropractic cause. This attempt, by the chiropractors, is not purely a local matter. This same effort is being made throughout the nation, in every state in which they have not, as yet, been successful in obtaining their own board. It might be interesting to note that during the recent National Convention of the American Legion, an attempt was made to place the Legion in the position of urging Congress to force the Veterans Administration to accept chiropractors for both in-patient and out-patient treatment in their hospitals. This measure was defeated after a floor fight by only 452 votes, which is considered a narrow margin.

During the summer months, the field secretary contacted the candidates for the legislature in an effort to learn the name of their family physician and to learn their views toward the chiropractic issue.

In reviewing these reports it has been noted, while the majority seem to agree with us that the educational standards should be maintained, never-the-less there is an indication of a feeling that the chiropractors perhaps are entitled to their own board, and that something should be done to bring an end to this long standing controversy. Therefore, it is apparent our effort to maintain the standards of medical education is not going to be any lighter in the coming legislature, and we respectfully request the complete cooperation of every member of the Association in the effort of the committee. It should be pointed out here, that your committee alone cannot do the job,—it will require the effort of all if we are to be successful.

The medical profession will also be faced with pressure being exerted on one hand by labor groups, and on the other hand by the insurance interests, manufacturers groups, and others with regard to a bill changing the provision of selecting physicians for care of cases falling under the Workman's Compensation Act. Labor is to introduce a bill which will permit an injured employee to go to the physician of his choice for treatment and/or surgery, rather than to go to the physician named by the insurance carrier or management. There is a variance of opinion within our own profession on this subject, and

certainly we must be careful in handling this matter. It is our plan to stay out of this controversy if at all possible. We cannot win regardless of the stand we might take. However, we are fearful tremendous pressure will be exerted to make us take a position in this matter. We would therefore appreciate your counsel and suggestions.

Another effort is being made by the committee to encourage every physician, his family and employees to make sure they are registered and that they cast their vote in the November election. We feel that never before has the medical profession had so much at stake during an election year and we trust every physician will use his franchise with care, for only with our friends do we have hope of success.

DONALD E. WOOD, M.D., *Chairman.*

HAROLD HALLECK, M.D.

GEORGE R. DANIELS, M.D.

ROBERT SMALLWOOD, M.D.

JOHN M. PARIS, M.D.

JAMES L. WYATT, M.D.

DANIEL D. STIVER, M.D.

WILLIAM C. VANCE, M.D.

WALTER F. KELLY, M.D.

## COMMITTEE ON PUBLIC RELATIONS

This year's activity of our committee has been marked with the publication of the "Newsflash" on a regular monthly schedule and cooperation with committees whose activities touched upon the field of public relations. As in the past the budget of the committee did not permit any additional activities other than the publication of the newsletter.

The "Newsflash" has served a useful purpose in keeping our members informed on matters which were not published in other form. The committee desires to express its sincere appreciation to the many members of the Indiana State Medical Association who have taken the time to write the committee and express their appreciation for the information made available to them through this medium. If mail is evidence, then this publication can boast of a large readership among the membership.

The committee was represented at the first national public relations institute by the chairman. This institute was by far the greatest step taken by the American Medical Association to assist the various states in their public relations problems.

The committee again this year cooperated in holding a press-radio dinner preceding the annual session at which time representatives of the press and radio were given an opportunity to ask questions regarding coverage of this meeting, and to receive information, in detail, concerning the program and the participants.

It is hoped that money will be available during the coming year with which the committee might begin serious work in developing a free-radio code, which has proved of great benefit to the profession of other states in handling ethical publicity

at all levels with the press and radio. This phase of the total public relations activity is considered of paramount importance by the American Medical Association.

It was noted that the Indiana State Medical Association ranks among the top states in the nation in the field of public relations, yet there have been many advancements made by our sister states in this field that deserve study by us. We hope this, too, will be accomplished during the coming year.

EARL W. MERICLE, M.D., *Chairman.*

JOSEPH B. DAVIS, M.D.

FRANCIS B. MOUNTAIN, M.D.

O. O. ALEXANDER, M.D.

GAYLE J. HUNT, M.D.

## COMMITTEE ON PUBLICITY

Your Committee on Publicity has met regularly throughout the year conducting the business assigned us. We have prepared and distributed our weekly newspaper health column entitled "Hints on Health" to more than 150 Indiana newspapers. In addition to this we have maintained a weekly radio program on Radio Station WFBM in Indianapolis and a few television programs over WFBM-TV. The committee would like at this time to recommend that the Indiana State Medical Association formally express its appreciation to the management of Radio Station WFBM and WFBM-TV for their generosity in providing us the time for these programs at no cost to the association.

### "Hints on Health"

One of the most important phases of the committee's activities is the preparation and distribution of the weekly newspaper health column "Hints on Health." We feel it is important that factual and accurate information be given the public on health subjects. With this in mind, we prepared the following articles for release during the past year:

Hurry-Worry Disease	Housecleaning
Acoustic Trauma	Artificial Respiration
The Knees Have It	Your Health
Child Safety	Sweating
Frostbite	Sedatives
Mental Illness	Don't Squeeze It
Juvenile Delinquency	2,640 More
Children's Habits	Cantankerous Cankers
Eyelid Dermatitis	Boils
Atomic Burns	Rheumatoid Arthritis
Duodenal Ulcer	VD Can Be Cured
Blood Circulation	Words Are Knowledge
Dust	Tularemia
Cat-scratch Fever	Marijuana
Infant Mortality	Measles
Accident Prone	Pathological Drinkers
Carbon Monoxide	Protect Your Child
Your Feet	Food You Eat
Teen-Age Addiction	That Cold
Man's Best Friend	Ingrown Toenails

Start Baby Right

Hypoproteinosis

Lead Poisoning

Your Sight

Hiccups

Birthmarks

Watch That Bull

Disease Knows Every-  
one

Play Safe—Live

Longer

Children's Eyes

Rabies

Spiders

Food Poisoning

Look Into Your Chest

Ability Counts

### General News Releases

The following general news releases were distributed to the papers of Indiana and the radio station news editors:

Quick Action Often Prevents Crippling when  
Polio Strikes

Medics Will Check Blood Pressures at State Fair  
Cure-all Gadgets Are Still Fooling American  
Public

General Story on Annual Convention

Annual Convention Program and Speakers

Auxiliary Convention Program

Fifty Year Club Members

Family Physician of the Year

Physicians Improve Their Public Service

The American Medical Association—A Public  
Service Organization.

### Radio Programs

The following 15 minute radio broadcasts were carried once each week over radio station WFBM. Each title denotes a 13 week series.

Doctor's Report

Gold Medal Doctors

Panorama of Research

Interlude

### Television Programs

The committee arranged a television program during last year which received much favorable comment. The program was conducted by Mr. George Larson of the American Medical Association staff, who exhibited and explained the display on Mechanical Quackery. This was an exhibit prepared by the AMA featuring the many items they had collected during the past few years which had been offered the public as a cure-all for illness.

### Publications

The pamphlet, "Getting Well at Home" reported last year, has since been published and distributed to the members of the Association. Additional copies have been requested by the State Welcome Wagon Service for their use in calling on new residents in various Indiana communities.

The committee has conscientiously endeavored to prepare and distribute material which would not only prove useful to the profession but the public as well. We invite at all times, suggestions from our membership on ways we might better our program.

S. D. MEGENHARDT, M.D., *Chairman*

JAMES O. RITCHEY, M.D.

HOMER G. HAMER, M.D.



## COMMITTEE ON RURAL HEALTH

The Rural Health Committee, at its first fall meeting decided to set up its program so as to be a logical extension of the work of the previous year. The following objectives were to be emphasized:

1. To continue to plan for procurement of doctors in rural areas.
2. To hold conferences of local physicians and officers of the State association, in order to discuss rural and health problems, and to acquaint the State Association with the "grass roots" thinking of the medical profession in Indiana.
3. To sponsor through the Woman's Auxiliary a series of conferences for the laity.
4. To sponsor, in conjunction with the Summer Agricultural Conference at Purdue, an annual health conference.
5. Finally, to continue working toward our long-range objective, the establishment of a State Health Council.

In order to organize and complete this rather ambitious program, individual responsibility for various aspects was accepted by members of the Committee. Reports from these individuals follow:

### I. Rural Physician Placement Service—Eli Goodman, M.D.

The following outline is offered as a basic plan in the matter of Rural Physician Placement Service:

1. Brochure to prospective physicians—interns and residents. This brochure might contain the following:
  - a. Location requiring physician.
  - b. An economic study of the location.
  - c. A pamphlet titled "Rural practice can be fun."
  - d. Outlines of suggested office plans with estimates of cost.
  - e. An outline of what the community offers to do in order to obtain and keep a doctor.
  - f. An individualized brochure cover.
2. Communities to be included in the brochure plan—selection of communities on the following basis:
  - a. A request for a doctor must be made by the community.
  - b. Ratio percentage of doctors per thousand population must be considered.
  - c. A priority plan for listing of communities in need of doctors must be established.
3. Community Contact Plan
  - a. Clarification of the legal aspects of small community practice in clinics or hospitals must be made.

- b. Smaller communities having local doctor must be educated to use that doctor regularly and considerably if they wish to keep him.

### 4. Community Responsibility

- a. Housing unit. A community wishing to obtain a doctor should make available adequate housing for the doctor and his family.
- b. Medical equipment. A community may participate in the purchase of necessary equipment.
- c. Office facilities (or clinic). A community may provide a loan to a doctor for the purpose of building an office or it may choose to remodel an existing building at community expense. It is desirable that the doctor have the option to purchase or rent same. The office facility should have certain minimum requirements.

### 5. Follow-up Literature

- a. A community which shows interest in meeting the minimum requirements, should be sent the following: building plans, equipment list, and cost estimates.

### II. Lecture for Classes at Indiana University Medical Center—J. E. Dudding, M.D.

The Committee felt that it might help encourage some of the new men getting out of school to enter rural practice. With that end in view Dr. Dudding gave a talk to the classes at the University Medical Center. This talk was divided into two parts. The first part was devoted to explaining the modern concepts of a rural practice today. It was pointed out that good roads, good automobiles, good hospitals, good laboratories, and good X-ray service are all within reach of the rural doctor. It was also pointed out that the close personal and professional relationship of doctor and patient is easier to establish in this setting, which, in turn, makes it easier for the doctor to establish his practice. The doctor, too, is able to practice a better brand of medicine because of this close relationship, and in addition, to become an integral part of a community and its life.

The second half of the talk consisted of a question and answer period. This portion of the discussion proved to be the most interesting part. The students were very cooperative, and asked many questions on all phases of the life of a general practitioner, both in city and rural areas. It was felt that the students enjoyed the discussion, and that they may have been enabled to formulate a more encouraging view of rural general practice.

Parts I and II of the Rural Health Committee's program has attracted the attention of

the AMA, who have sent a representative to our state headquarters to study the program.

### III. Local Conferences—Robert W. Kuhn, M.D.

These local conferences, authorized by the House of Delegates, were held at the following places: Linton, Columbus, Lafayette, Muncie and South Bend. At each of these conferences a different member of the committee was responsible for chairing the meeting. The preliminary part of the program was similar in each case; Dr. William J. Wright, President of the State Association, presented the several functions and duties of the State offices. Dr. Donald A. Wood reviewed the program of the Committee on Public Policy and Legislation, emphasizing the need of the medical profession to improve public relations, improve medical care, to inform the public of our program, to advise the public politically, and to encourage the public to vote for the best man for office. After this the meeting was thrown open to general discussion of topics which the doctors present thought of paramount interest. Again and again, throughout these discussions, the following subjects were brought up:

1. The procuring of young physicians for rural areas.
2. Over-specialization of the profession.
3. The real rewards of rural practice.
4. The need for revision of the curricula offered in the medical schools.
5. Health Councils.
6. School health programs, especially the immunization programs.
7. Insurance programs—especially the competitive aspects.
8. Round-the-clock service to the community on an organized basis.
9. Need for more nurses.
10. The political aspects of medicine and the fight against communism.

### IV. Health Workshops—Bluffton and Bloomington—Mrs. Jack Eisaman.

Mrs. Jack Eisaman, the chairman of Rural Health for the Woman's Auxiliary, did a splendid job in organizing and setting up the program for the two Health Workshops at Bluffton and Bloomington. Panels on Heart, Cancer, Nutrition, and Mental Hygiene were arranged with four speakers on each panel. After the panel, the subject was thrown open for general discussion. Keen interest was shown throughout both workshops and many favorable comments were received, including requests that more such programs be made available to the public. Over a thousand persons were in attendance at the two workshops,

an indication of the interest of the lay person in the subject of better family health.

### V. Annual Rural Health Conference at Purdue University—L. E. How, M.D.

The annual Rural Health Conference was held at Purdue with 250 attending in the morning and 700 in the afternoon. The morning discussion centered around "Rabies and Human Health" with a panel chaired by Mrs. Jack Eisaman, Rural Health Chairman of the Woman's Auxiliary. John Bretz, M.D., Huntingtonburg, discussed "Rabies, a Threat to Health"; L. M. Hutchings, D.V.M., Purdue, "Rabies and Livestock"; George Doup, Indiana Farm Bureau "Economics and Rabies"; and Gerald F. Kempf, M.D., Indianapolis, "Legislative and Public Aspects of Rabies." This was followed by a discussion of rural health problems by Thurman B. Rice, M.D., of the State Board of Health.

The afternoon session was chaired by F. S. Crockett, M.D., chairman, Rural Health Council, AMA. Dr. Crockett introduced J. William Wright, M.D., President, Indiana Medical Association, who gave the opening remarks. He was followed by H. J. Reed, Dean and Director of Agriculture, Purdue, who spoke on "Health and Agriculture." Then George W. Crane, psychologist and columnist (author of syndicated "Worry Clinic") spoke on "Mental Health" to close a very successful conference. Dr. Crane's appearance on the program was directly due to his friendship with Dr. Himebaugh, a member of the committee.

### VI. State Health Council

As stated in last year's report—and repeated in this—the Committee is still of the opinion that a State Health Council should be established. Several lay groups are doing preliminary planning in this field, and if the medical profession does not help to give leadership, we will inevitably have to follow—it may be in directions not too pleasing to the profession. Dr. Goodman, and a subcommittee of Drs. Habegger and Bretz, are working on plans which are not sufficiently complete to present in this report.

The Committee sent representatives to the Annual Conference on Rural Health at Denver, conducted by the AMA Council on Rural Health, and to the Kentucky Annual Conference on Rural Health.

### Denver Conference

The Seventh Annual Rural Health Conference of the AMA was held in Denver, February 28 and 29 and March 1, 1952.

The first day was devoted to a meeting of State Rural Health Committees, the Council on Rural Health of the A.M.A. and Health Educators. The theme of the day was "The Physician as a Citizen."



The Friday and Saturday meetings included the above personnel plus representatives of many farm organizations. The theme of these two days was "Help Yourself to Health."

The program included such well known persons as: John W. Cline, M.D., President of the A.M.A.; F. S. Crockett, M.D., Rural Health Chairman of the A.M.A.; George F. Lull, M.D., Secretary and General Manager of the A.M.A.; Mrs. Harold Wahlquist, President of the Woman's Auxiliary to the A.M.A.; Robert Stearns, L.L.D., President of the University of Colorado, and Albert C. Yoder, M.D., General Practitioner of the Year.

Many fine papers were presented and a mutual feeling of inspiration was experienced.

Cooperation was emphasized between the physician, health workers, extension agents, county health nurse and health officers, state board of health, county and state medical associations, organized farm groups, voluntary health organizations, educators, PTA groups and the individual.

The place of the doctor in his community was discussed and much stress was placed on his assuming a role of leader and advisor in all problems relating to health.

The topic of Health Councils was given extreme importance. Doctor Cline urged the formation of community health councils. He stated, "We must start before it is too late. I urge you to start your own action program. The community health council is one specific objective toward which you can guide your efforts as an individual."

Dr. Crockett stated, "The entire health problem of rural America is in the process of solution. It is our privilege and duty as doctors and as health educators to encourage this program of local health councils. The medical profession, through the A.M.A., has evolved this method as an answer to the need of local health facilities and personnel."

Some of the various projects of local health councils have included: nutrition surveys; diabetes detection work; improved sanitation; location of doctors in rural areas; provision of more adequate medical, dental and hospital facilities which will attract more doctors; information to farm people of available services and how they can help solve their own health problems; encouragement of voluntary health insurance; immunization programs; provision of programs to teach Home Nursing and First Aid; cancer clinics; fluorination of water supplies; child guidance clinics; school health improvement and cooperation with existing health agencies.

The Health Council is in operation in many states and wherever it is being used the results have been favorable.

Colorado University feels it is contributing to Rural America by offering a three year residency in General Practice. This program was discussed at great length. Four outlying hospitals in the

state have been approved for part of the training program. The resident works with the local doctors. Once a month a teaching team from the University goes to the hospitals and holds clinics with the resident and local doctors. This experience has been of mutual benefit. The resident acts as the family physician to his patients, experiences a full medical program, has an opportunity to observe hospital management and even has an opportunity to learn the doctor's business methods. The University favors this program as do those who have been trained in it.

The University of Virginia sends its interns who are interested in General Practice into rural hospitals for a 4-6 month period. Several cases of doctors taking medical students for the summer months were mentioned. These experiences seem to interest young doctors in the rural practice of medicine.

Dr. Kenneth Kaisch told of his experiences in locating in a rural area, Philip, South Dakota. He said for a rural area to obtain a doctor it should: "Provide adequate hospital facilities and personnel, office space for the doctor to rent and the type of town in which a person would want to live. To keep a doctor treat him as a human being with the same mental outlook and physical stamina as yourselves. Try working with him instead of against him." He pointed out that many small towns have more trouble keeping a doctor than getting one.

The extension service representatives of our land grant colleges were much in evidence at this meeting: some gave papers, many participated in the discussions and their work was commented on and complimented by many physicians. Their service is one of education and ties in closely with our medical program. In many states the extension service works hand in hand with the medical profession in the formation of health councils, in finding and relieving local health needs and presenting a better health program to the rural people.

It was often brought out that "Health is more than medical care." It is a good way of living. To preserve our American way of life we must preserve our democracy. By helping ourselves on a local level we can stamp out the "cancerous growth of socialism which is sickening the vitals of our country." All farm organizations are with us in our program and eager for the doctors and the farmers to stand together in the fight to keep freedom alive.

There was a spirit of mutual confidence, helpfulness and good-will in the meeting. The needs and plans of action were studied. Now we must strive in a unified effort to solve our Rural Health problems.

In Dr. Cline's closing words, "We have come a long way. We have a long distance still to go and

it will require energy, determination and teamwork to get there."

LOUIS E. HOW, M.D., *Chairman*  
J. E. DUDDING, M.D.  
M. L. HABEGGER, M.D.  
ELI GOODMAN, M.D.  
ROBERT W. KUHN, M.D.  
SAM ROTMAN, M.D.  
JOHN M. BRETZ, M.D.  
GILBERT HIMEBAUGH, M.D.

## ALCOHOLICS STUDY COMMITTEE

There were no meetings of the Committee on Alcoholics Study since no business was referred to the Committee.

LOUIS W. NIE, M.D., *Chairman*  
LOWELL F. BEGGS, M.D.  
JOHN H. HARE, M.D.  
WILLIAM D. GAMBILL, M.D.

## AUDITING COMMITTEE

The Auditing Committee held its annual meeting on July 23, 1952, in the Indiana National Bank, Indianapolis. Investments of the association, as listed below, were examined:

### General Fund:

United States Savings Bonds, Series G	\$36,000.00
United States Savings Bond, Series K	25,000.00
United States Treasury Bonds	5,000.00
	<hr/> \$66,000.00

### Medical Defense Fund:

United States Savings Bonds, Series G	\$13,000.00
United States Savings Bonds, Series K	1,000.00
United States Treasury Bonds	5,000.00
	<hr/> \$19,000.00

Cash balances in the Indiana National Bank, the American National Bank, The Fletcher Trust Company, and the Bankers Trust Company, as shown by the June, 1952, bank statements, also were examined. These accounts consist of the General Headquarters Office Fund, the Medical Defense Fund, THE JOURNAL Fund and the Petty Cash Fund, respectively, and show the following balances as of July 1, 1952:

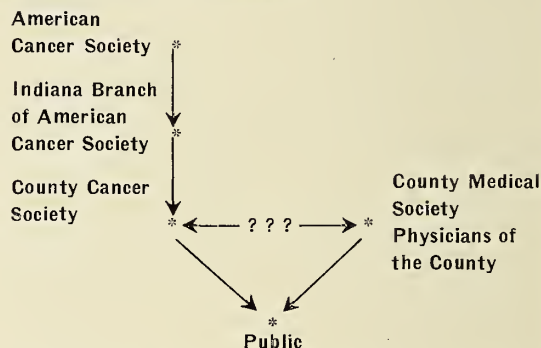
General Fund	\$ 97,980.45
Medical Defense Fund	5,318.96
THE JOURNAL Fund	12,040.53
Petty Cash Fund	367.62
	<hr/> \$115,707.56

MAURICE V. KAHLER, M.D., *Chairman*  
ALBERT M. DONATO, M.D.  
EDWARD F. BLOEMKER, M.D.

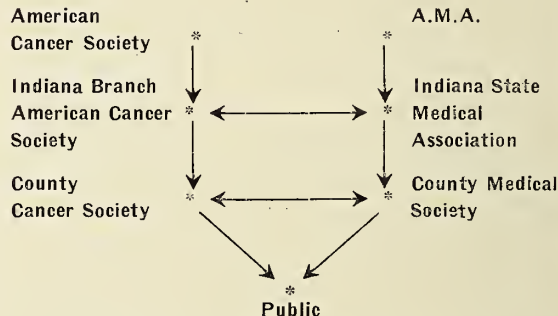
## COMMITTEE ON CANCER

The Committee on Cancer of the Indiana State Medical Association has given consideration to the following subject matter which is presented here for the attention of the members of the state association. At present the Indiana Cancer Society and the Indiana State Medical Association give very little mutual consideration to informing and aiding the public in cancer problems.

### The Present Cancer Program In Many Parts Of Indiana



The public would greatly benefit by cooperation and close relations between the Cancer Societies and the Medical Societies—beginning at the State level.



The neighborhood doctor should attend and address civic clubs and organizations at their meetings on cancer.

All physicians should be warned against making light or belittling the patient's idea that they might have cancer. Sure they have read the Reader's Digest and the Ladies Home Journal, but maybe they *do* have cancer.

More should be said about the family doctor's office being the diagnostic clinic where people should get their information about cancer problems.

O. W. SICKS, M.D., *Chairman*  
LALL G. MONTGOMERY, M.D.  
HAROLD M. TRUSLER, M.D.  
FRANK M. SCOTT, M.D.  
MELL B. WELBORN, M.D.  
MERRILL S. DAVIS, M.D.



## COMMITTEE ON CHRONIC ILLNESS

The Indiana State Medical Association met with the Governor's Committee on Chronic Illness on June 18, 1952. Herewith is presented a report of their activities:

**Those Present:** F. R. Nicholas Carter, M.D., Miss Nellie Brown, R.N., Mr. Warren Edwards (representing Mr. Maurice Hunt), J. D. Van Huysen, D.D.D. (representing Arthur L. Harter, D.D.S.), Leroy E. Burney, M.D., M. C. Pitkin, M.D., Cletus L. Krag, M.D., Division of Tuberculosis and Chronic Diseases, USPHS, Wendell C. Anderson, M.D., Wm. F. King, M.D., Miss Lucille Wall, R.N., Mr. Robert Yoho and Miss Joan Schaub of the Division of Health Education.

**Presiding:** Dr. Carter

**Recording:** Dr. Anderson

**Weight Control Releases**—Copies of eight releases on weight control were distributed to all members present for their consideration. The group approved the releases as written for distribution to all newspapers in the state. A copy of the series is to be sent to all members of the Chronic Illness Committee of the Indiana State Medical Association and to Mr. James A. Waggener, Executive Secretary to the State Medical Association, before being released to the newspapers. The name of a member of either of the above named committees residing in a specific locality might be quoted in the newspapers in that locality.

**Radio Series**—Dr. Anderson submitted a list of topics which might be used for a series of radio programs with Catherine Daniels on WISH. The group considered the advisability of them sponsoring such a program.

It was agreed that the topics should be reworded in order that they might be in agreement with the responsibilities of the Indiana Committee on Chronic Illness.

It was agreed that a member of one of the committees and a representative from the State Board of Health appear on each program.

**County Homes**—A sample copy of a proposed medical record for County Homes was presented to the group. The homes will be urged to use this record unless they have already developed their own which is more suitable. The State Department of Public Welfare will furnish the record of the homes. The committee approved the record.

A discussion on the need for policies for the supervision and care of residents in county homes brought out the need for committees being better informed about the situations existing in county homes. It was decided to have the next joint meeting of the committee de-

voted to presentation of factual information about the county homes.

**Reports on Preparation of Institute**—Dr. King presented the plans for an institute on retirement in industry to be held July 28 and 29 at the Purdue University Union Building. He was asked to express the interest of these two committees in the institute.

He also reported that an institute on gerontology will be held at Indiana University September 25 and 26.

**Kit on Chronic Disease**—A kit containing literature on Chronic Diseases available from the State Board of Health in a limited supply was presented to each member present. Dr. Carter asked that absent members of both committees be sent a kit. It was suggested that those distributed in the future would carry on the cover:

Distributed Jointly by

Indiana Committee on Chronic Illness,  
Committee on Chronic Disease, Indiana  
State Medical Association

Indiana State Board of Health

The next meeting of the committee was to be held Wednesday, September 24. A copy of compiled information on County Homes was sent to all members one week before the meeting. It was announced that preliminary plans have been made to have members of the two committees appear with Gilbert Forbes on WFBM-TV the night preceding this meeting. Dr. Carter has selected Miss Brown and Dr. Edgar Kiser to appear with him and both have accepted the assignment.

F. R. N. CARTER, M.D., *Chairman*  
J. T. OLIPHANT, M.D.  
JOHN D. VANNUYS, M.D.  
M. C. PITKIN, M.D.  
C. R. HERD, M.D.  
BERNARD ROSENAK, M.D.

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## COMMITTEE ON CIVIL DEFENSE

In November 1951, the chairman attended a four-day conference sponsored jointly by the American Hospital Association, the American Medical Association, the Association of State and Territorial Health Officers and representatives of the Federal Civil Defense Administration. The information gathered at this meeting was reported to the I.S.M.A. Council on January 13, 1952 and permission was secured to present a county civil defense plan through our state Journal. This article was published in the April issue of THE JOURNAL.

Meetings on civil defense organization were addressed by a member of the Committee before the Tipton County Medical Society on January 23, and the Randolph County Medical Society on

March 10. On February 27, the chairman attended a meeting of representatives of all of the railroads in Indiana and presented the problem of hospital trains which our medical evacuation plans call for, to move patients to fixed support counties 100 miles or more from an attacked target area. It was established that all rail facilities within the state will operate under control of the state mobile support headquarters and that no plans or agreements should be made by the railroads with county or local units.

On April 3, the Civil Defense Committee of the State Association met at the State Board of Health Building with representatives of the State Nursing Association and the State Dental Association to coordinate present civil defense planning. On April 21, Dr. Lee spoke before the Medical Social Workers of Indiana on medical civil defense plans. April 26 and April 27, the chairman attended a two-day conference of the Council on National Emergency Medical Services on medical civil defense and also participated in a one-day round-table discussion on June 10, during the A.M.A. Convention. From one to three members of the committee attended meetings of the Health and Medical Branch of the Indiana Department of Civil Defense once or twice monthly except during the summer months.

A number of meetings were necessary with representatives of the wholesale pharmaceutical houses in Indiana and the State Budget Committee to arrange for state funds to be used in matching federal funds for the purchase of first aid sets.

Dr. James Leffel, co-chairman of the committee, has spent considerable time selecting the instruments, drugs and supplies to be included in these first aid sets. He was aided in this matter by advice from various members of the faculty of the Medical School.

Considerable difficulty was experienced in getting the release of state funds which had been appropriated for civil defense purposes by the last Legislature on a contingent basis. Because of the contingent basis upon which these funds were allocated to the civil defense fund, the law was interpreted to authorize the expenditure of these funds only if an atomic attack had occurred in Indiana. It was, therefore, necessary to convince the Governor, the Budget Committee and to secure the cooperation of the State Civil Defense Council to determine that the situation was more critical now than it had been when the Legislature appropriated these funds in order that a sufficient amount of the \$500,000 appropriated for civil defense could be used in matching federal funds to permit the purchase of these first-aid sets.

When all of the items to go into these first-aid sets have been received in Indiana, they will be packaged as sets by the state and will then be distributed to each major target area on the basis of one first-aid set per first-aid station planned by the

local target areas themselves. Some civil defense organizations in mutual aid and fixed support areas have raised funds locally for the purchase of first-aid sets for their medical civil defense organization. In addition, about one-fourth of the first-aid sets will be held in state stockpile from which they can be moved as the need arises.

At the end of the Civil Defense Conference held in Chicago in November 1951, a resolution was adopted by those in attendance setting a goal that every physician in the United States be assigned to his role in the civil defense organization by the time that the next annual Civil Defense Conference is held in November 1952. Indiana will be required to report on her achievement along this line this November and every county will be requested to report, to the State Civil Defense Committee, their degree of organization and assignment of physicians to civil defense assignments in answer to a questionnaire which will be mailed out in October by the State Civil Defense Committee.

If every county outside of major target areas and some counties in mutual aid areas who have working agreements with the target areas to which they are satellite, will organize along the lines recommended in the article on civil defense organization published in the Indiana State Medical Journal in April 1952, then Indiana can report one-hundred percent achievement toward this goal.

GLEN WARD LEE, M.D., *Chairman*

JAMES M. LEFFEL, M.D.

RAY ELLEDGE, M.D.

CHARLES W. MYERS, M.D.

KENNETH OLSON, M.D.

WILLIAM O. BALDRIDGE, M.D.

M. B. CATLETT, M.D.

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## COMMITTEE ON CRIPPLED CHILDREN SERVICES

The Committee on Crippled Children Services has had no communications or problems referred to it during the past year. For that reason the Committee has not held a meeting. We, therefore, have nothing to report at this time.

WAYNE R. GLOCK, M.D., *Chairman*

HARVEY SIGMOND, M.D.

JOSEPH C. LAWRENCE, M.D.

LELAND G. BROWN, M.D.

LEO K. COOPER, M.D.

WILLIAM B. FERGUSON, M.D.



## COMMITTEE ON DIABETES

The most important function of your Committee on Diabetes during the past year has been to assist with the annual diabetes detection drive. This, as you know, was first sponsored by the American Diabetes Association several years ago, and for the past three or four years there has been splendid cooperation by the doctors of Indiana.

A number of county medical societies have had diabetes committees for the past several years. The Marion county committee, headed by Dr. I. W. Wilkins, did a great deal of work last fall and had the splendid cooperation of a number of the doctors throughout Marion county. Many urine tests were made in doctors' offices throughout the city and many other tests carried out by physicians in the industrial plants throughout this community. Tests also were made by the Board of Health and other agencies. A great number of tests were made and the positive reports were given to the Diabetes Detection Committee. Several undiagnosed cases of diabetes were discovered in Indianapolis during that drive.

During the 1951 State Fair the Indianapolis Diabetes Association, in conjunction with the State Board of Health and the Indiana Society of Technologists, made a great number of microscopic blood sugars. Several thousand tests were made and a number of new cases of diabetes were discovered. Those individuals who had high blood sugars were advised to consult their family physician so that further blood and urine tests could be made and the diagnosis definitely established, and if proven to be true diabetics, treatment was then instituted. This, we believe, can again be carried out on a larger scale in a few years.

The American Diabetic Association each year sponsors this national drive for the detection of new cases of diabetes. This year the week of November 16 to 22 inclusive has been designated as the period for the diabetes detection drive. Local medical societies, independent physicians and manufacturing plants, as well as the schools and other types of institutions will be supplied without charge the material for making urine tests. Those tests which are found positive will, in turn, be reported to the individual's family physician so he can decide whether or not treatment is necessary in each individual case. We are sure that the members of the county medical societies throughout the state will be only too glad to cooperate in this drive. Material for making urine tests can be obtained in the quantities desired by writing to the American Diabetes Association, 11 West Forty-second Street, New York 36, N. Y.

We hope to be able to have an opportunity to announce to the people of Indiana by radio, television, newspaper and other mediums, this detection drive and hope that many of them will present themselves to their family doctors, private laboratories, hospital laboratories and their places of employment so that these tests can be made. This

is particularly important for individuals who have histories of diabetes in their families, or are inclined to be overweight, or present any of the symptoms suggestive of diabetes. We hope to have the assistance of some of our pharmaceutical houses, drug stores and larger department stores to help with the publicity, so that we can have a more complete and successful detection week than we have ever had in the past. The Indianapolis Diabetes Association, which is composed of both a professional and lay group, is more than glad to give all the help and assistance that is possible in carrying out this diabetes detection plan during the week of November 16 to 22 inclusive, and we believe that as other local diabetic groups are established throughout the state that the success of this type of endeavor, as well as other assistance to diabetics will be made available to all of our patients.

JOHN H. WARVEL, M.D., *Chairman*

MARSHALL I. HEWITT, M.D.

GEORGE W. WILLISON, M.D.

WILLIAM D. GAMBILL, M.D.

E. O. DANIELS, M.D.

STANTON L. BRYAN, M.D.

CHARLES F. SEAMAN, M.D.

DALE D. DICKSON, M.D.

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## COMMITTEE ON FOOT HYGIENE

No report.

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## COMMITTEE ON HARD OF HEARING

The Hearing Committee has held no meeting during the past year and therefore has no report.

GUY A. OWSLEY, M.D., *Chairman*

HUGH A. KUHN, M.D.

R. R. CALVERT, M.D.

J. C. TRAVIS, M.D.

CARROLL O'ROURKE, M.D.

J. WILLIAM WRIGHT, Jr., M.D.

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## COMMITTEE ON HEART DISEASE

Several educational programs were given the encouragement of the Committee on Heart Disease during the year 1951-52. Among these was the demonstration of the Heart Kitchen at the Agricultural Conference at Purdue University July 29, 30, and 31. This committee has been pleased to cooperate with a group under the leadership of Mrs. Kathryn Sheedy, nutritionist of the Lilly

Clinic for preparation of a film, "The Heart and Diet". This material will be of value to those cardiac patients who have been placed on restricted low sodium diets.

The August issue of *THE JOURNAL* carried this committee's report on the use of ACTH and Cortisone in the treatment of Rheumatic Fever. This was a preliminary report of the findings made by the Council on Rheumatic Fever and the American Rheumatism Association.

Both the University Hospital and the Indianapolis General Hospital have succeeded in getting new equipment to further research developments in heart disease. This committee is intensely interested in the stimulating developments that may result from the work of this group.

STUART R. COMBS, M.D., *Chairman*

DAN URSCHER, M.D.

WALTER S. FISHER, M.D.

RICHARD NAY, M.D.

C. J. CLARK, M.D.

PHILIP W. ROTHROCK, M.D.

## INDIANA A.M.A. CAMPAIGN COORDINATING COMMITTEE

This committee has carefully observed the status of national compulsory health insurance legislation during this year, and, therefore, has been relatively inactive. We have taken this course in keeping with the program of the American Medical Association's compulsory health insurance committee, and in accordance with the thinking of the officers of the State Association.

National legislation, to establish a federal compulsory health insurance program has been quiescent this year. For that reason it has been deemed inadvisable to carry out the intensive drive against socialized medicine this year that has characterized the activities of the committee during the previous three years. Medical leaders have felt that this was the time for improving the position of the medical profession by a long range program of better public relations by the medical profession as a group, by individual physicians and by various committees of our association concerned with many features of the program.

This committee has assisted the Public Relations Committee and the Legislative Committee in carrying out this program. We have filled all requests for speakers on socialism and have arranged for the showing of a film on the subject before various regional school health conferences to be held during the coming months.

Resolutions are still coming in from various organizations opposing compulsory health insurance

and these have been forwarded to members of Congress as well as to the A.M.A.

As this report is printed it is impossible to outline the activities in which this committee should engage during the coming election. Both General Eisenhower and Governor Stevenson have declared themselves opposed to socialized medicine. General Eisenhower has been more forceful in statements in that regard, and the platform of the Republican party is more definite in its opposition to compulsory health insurance. Yet utterances of Governor Stevenson and the Democratic platform are such that one would conclude that they may wish to forget the whole thing. The committee is still looking to the A.M.A. for guidance as to what we should do in this regard.

This committee has voted to use its efforts to urge that everyone vote in the coming election. We propose to do this by printing a large number of posters to be installed in physician's offices, hospitals, drug stores, etc., calling the attention of the reader to this responsibility and assuring him that the Indiana State Medical Association members are interested in good government.

It is the opinion of the members of this committee that future activities of this committee and of the medical profession individually should be determined as the political campaign progresses.

CLEON A. NAFE, M.D., *Chairman*

C. H. MCCASKEY, M.D.

WALTER L. PORTTEUS, M.D.

KARL R. RUDELL, M.D.

## COMMITTEE ON INDIANA INTER-PROFESSIONAL HEALTH COUNCIL

No report.

## COMMITTEE ON INFANTILE PARALYSIS

The Infantile Paralysis Committee has had no formal meetings during the past year. As a result we have no formal report to make on our activities during this past year.

KENNETH T. KNODE, M.D., *Chairman*.

LEROY E. BURNEY, M.D.

PALMER EICHER, M.D.

EUGENE W. AUSTIN, M.D.

JAMES KIRTLEY, M.D.



## COMMITTEE ON INSTRUCTIONAL COURSES

Your Instructional Course Committee for the arrangement of instructional courses for the 1952 session of the Indiana State Medical Association wishes to report that its program has been completed and that the curriculum offered for the 1952 session will be of the usual high standard for this feature of the convention session.

The host society, the Indianapolis Medical Society, will provide the members of the faculty. It is anticipated that all of the 30 courses offered will be fully attended by the limited enrollment of 30 members for each course.

E. PAUL TISCHER, M.D.  
J. LAWRENCE SIMS, M.D.  
FLOYD T. ROMBERGER, JR., M.D.  
ARTHUR N. JAY, M.D.  
JOHN VAN NUYS, M.D.  
SETH W. ELLIS, M.D.  
RUSSELL SAGE, M.D., *Co-Chairman*  
GORDON W. BATMAN, M.D., *Co-Chairman*

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## COMMITTEE ON MATERNAL AND CHILD HEALTH

During the past year, the Committee on Maternal and Child Health held two meetings. A summary of the activities of this Committee are as follows:

### PREMATURE CENTER

The Committee still has the project of the establishment of a premature center in the state for the care of premature infants and for training of doctors and nurses at the Indiana University Medical Center under study. The problems are of considerable extent. The greatest of these being the lack of facilities and funds.

The Medical Center and the State Board of Health recognize the need for this center and will continue to work with its Committee to make plans for a premature center.

### BROWN COUNTY HEALTH CENTER

A health or community center building, to be located in Nashville, Indiana, with clinic facilities for maternity and public health nursing activities has not materialized as yet due to lack of funds and perhaps education of the local community to the need.

The Committee will work with the local community upon request and lend its support to the establishment of such a center.

### EDUCATION IN MATERNAL AND CHILD HEALTH

The Committee favored the dissemination of information to the general public, high school stu-

dents, young adults and expectant parents regarding healthy parenthood.

Education on the necessity of early medical, prenatal care, in order to prevent and reduce the number of deaths and complications, has been considered by this Committee.

The Committee will assist the Division of Maternal and Child Health of the Indiana State Board of Health with suggestions on preparation and approval of plans, educational materials, or teaching guides for education under medical supervision.

Members of this Committee will continue to help with the planning and will participate in regional institutes for nurses on obstetrics and pediatrics. The Committee functioned in a recent meeting.

In conclusion, the Committee on Maternal and Child Health regrettably announces the resignation of one of its members, Robert E. Jewett, M.D., former Director of the Division of Maternal and Child Health, Indiana State Board of Health. His contributions to the activities of this Committee have been many and his presence will be greatly missed.

NEAL E. BAXTER, M.D., *Chairman*  
G. W. GUSTAFSON, M.D.  
REX W. DIXON, M.D.  
E. R. CARLO, M.D.  
C. O. McCORMICK, SR., M.D.  
H. W. EGGERS, M.D.  
CARL P. HUBER, M.D.

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## PERMANENT STUDY COMMITTEE ON MEDICAL CARE INSURANCE

The committee first met at Indianapolis on February 24, 1952. Shortly prior to this meeting the Department of Internal Revenue had ruled on fee division. As one step to aid in this problem, it was proposed that Blue Shield issue two checks, when requested, one to the surgeon and one to the doctor assisting at the operation. The proposal was discussed at length. Much of the discussion was on whether or not an amount or percentage for the second check should be suggested. It was decided that no division could be suggested which would be fair under all circumstances. The committee felt that the doctors should determine by mutual agreement the amount of each check and fill out the return accordingly. It was understood that the sum total of the two checks should not exceed the amount of the indemnity set forth in the fee schedule.

The committee also considered the Novy Resolution passed by the House of Delegates of the American Medical Association at Los Angeles in 1951. This resolution had to do with the medical care of the dependents of men in military service.

The committee had little information on this matter and agreed to follow the lead of the American Medical Association.

These two actions by the committee were presented to the House of Delegates on April 27, 1952. The first, the one dealing with two checks, was adopted. The second, having to do with the Novy Resolution, was tabled at the suggestion of the reference committee.

At a later date the chairman of the committee was asked to meet with the Board of Directors of Mutual Medical Insurance, Inc. At this meeting it was pointed out that the directors were hesitant to issue two checks because they felt that by so doing they might under certain circumstances aid, abet or become a party to the splitting of a fee. It was agreed that the committee on medical insurance would meet in the near future to consider the objection of the directors.

Prior to the meeting we received communications from the American Medical Association, the American College of Surgeons, the Wisconsin Blue Shield and a practicing physician in Wisconsin.

The action of the committee was as follows:

"The Permanent Study Committee on Medical Care Insurance fully discussed the objections raised by the Board of Directors of Mutual Medical Insurance, Inc., The Blue Shield Plan, to the resolution adopted by the House of Delegates of this Association on April 27, 1952, in which it was recommended that the Plan devise a method for issuing two checks, when desired, in cases of surgery where a participating physician is used as an actual assistant. This committee communicated with the American Medical Association and the American College of Surgeons, and they inform us the proposal as made by the House of Delegates would not in their opinion constitute fee-splitting. Information has also been received from the Wisconsin Blue Shield Plan in which it is learned they follow such a system and that it has met with the approval of their physicians. In view of this information, this committee desires to reaffirm its previous resolution, submitted to and approved by the House of Delegates on April 27, 1952, and hereby requests the Council and the House of Delegates of this association to again approve our request that Mutual Medical Insurance, Inc., The Blue Shield Plan, devise a system of issuing a separate check to the surgeon and the participating physician, the total of the two checks not to exceed the total amount of the indemnity provided for in the Master Fee Schedule."

It should be noted that the words "participating physician" are used replacing the word "assistant" which was used in the original motion as passed by the House of Delegates.

On July 27, 1952, the chairman of the committee appeared before the Council of the Indiana State Medical Association. The communications were read to the Council and after considerable discussion the action of the committee was approved with a slight change in the wording of the motion.

The two words "if desired" were inserted after the words "issuing of two checks."

In view of the study made by this committee as outlined above and since the Council has reaffirmed our position in this matter, we, therefore, at this time respectfully request this House of Delegates to also re-affirm its previous action by adopting this report.

MAURICE V. KAHLER, M.D., *Chairman*  
NATHANIEL C. ISLER, M.D.  
RAYMOND C. BEELER, M.D.  
JOSEPH E. DUDDING, M.D.  
FRANK GREEN, M.D.  
FLOYD S. NAPPER, M.D.  
FRANCIS P. JONES, M.D.  
LALL G. MONTGOMERY, M.D.  
D. D. STIVER, M.D.  
CLIFFORD M. JONES, M.D.  
A. W. CAVINS, M.D.  
JAMES S. McELROY, M.D.  
WILLIAM C. REED, M.D.  
FRANCIS B. MOUNTAIN, M.D.

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## COMMITTEE ON MEDICAL AND NURSING SCHOOL SCHOLARSHIPS

No formal meeting of the Committee on Medical and Nursing School Scholarships was held since action of the House of Delegates in abandoning the medical and nursing school scholarship fund curtailed the activity of the committee. However, the committee was continued as an active one since the final payment to a student now receiving such scholarship aid will not be made until 1954. Four nurses now receiving scholarships will complete their work in 1953, as will one other medical student. No nursing scholarship will be continued after 1953.

Two young physicians, recipients of scholarships, who completed their intern training in June of 1952, have selected small towns in Indiana for their practice, as stipulated by the agreements of the fund. Dr. Herbert C. Ashmore began practicing in Hebron on July 1, 1952, and Dr. Earl R. Leinbach began his practice of medicine in Hamlet on the same day. These communities were in need of doctors and the committee has approved their selection by the scholarship recipients. The committee is pleased to report that these men have



carried out their obligations and that they are taking their places in areas where the need is great.

JAMES M. KIRTLEY, M.D., *Chairman*

JAMES L. LAMEY, M.D.

PAUL J. FOUTS, M.D.

*Ex-officio*

J. WILLIAM WRIGHT, M.D.

WEMPLE DODDS, M.D.

DONALD E. WOOD, M.D.

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## COMMITTEE ON MENTAL HEALTH

Summarizing observations and informal discussions of the year, your Committee on Mental Health in a meeting on August 14 drafted the following report which it is pleased to submit for the approval of the House of Delegates.

### I. Public Psychiatric Services.

The public psychiatric services of Indiana continue to be rated very low in comparison with other states. (About forty-third on a basis of per capita expenditure.) This indisputable fact is repeatedly publicised and is made the basis for continuing demands for improvement.

Such low per capita expenditure for the care of the mentally sick cannot be viewed as praiseworthy economy. Unfortunately, it reflects inadequate medical and psychiatric treatment.

Greater exploitation in our psychiatric (and penal) institutions of modern techniques of treatment would unquestionably reduce their case-load and prove in the long run to be truly economical.

Not only in respect of inadequate funds is our system of administration of the public psychiatric services deficient. The system suffers from lack of centralized, professional, non-political authority. With full appreciation of the earnest and generous efforts of the trustees of the several institutions, and of the members of the Council For Mental Health, your committee finds that these agencies are not provided by law with the machinery for co-ordinating their aims. Overlapping authorities have stood in the way of a comprehensive plan for modern treatment. Development and modernization have been constrained not only from lack of a central planning authority, but because it is impossible for a general Personnel Board, Central Purchasing Board, and Budget Committee to be sensitive to the particular needs of the psychiatric institutions. The operation of this complex system of management has indeed resulted in conflict, confusion, and stagnation.

Recognizing that the care of a large percentage of the mentally ill is necessarily a social responsi-

bility and therefore subject to governmental provisions, your Committee proposes that each political party be asked to pledge support of an aggressive program of rehabilitation of the public psychiatric services, making definite commitment on the following specific recommendations.

(a) Means should be found to allocate money from abundant State funds to enable the psychiatric services to obtain a full complement of employees, both professional and ancillary, at salaries which will enable Indiana to compete successfully with other states for personnel.

(b) In the utilization of funds provided, the administration of the psychiatric institutions should be freed from stringencies imposed by the Budget Committee and other state bureaus. Instead, complete responsibility for the professional success and economic operation of the psychiatric establishments should be given to a professionally trained commissioner, or commission, responsible directly to the Governor and the General Assembly.

(c) The Boards of Trustees of the several institutions and the Council for Mental Health, all consisting of practically unpaid members giving part-time, voluntary service should be given advisory functions subordinate to the Commission.

(d) The re-organized system of psychiatric services herein proposed should be so designed as to be completely free from the demoralizing influence of party politics at the top or local levels. Political influence should end with the appointment of the central authority which thereafter should be entirely responsible for the success and economy of the system, and subject to removal if extravagant or unsuccessful.

(e) The central psychiatric authority should be required to set up its own personnel board and should not be constrained by the standards of a general personnel board which cannot know the special requirements of mental hospitals.

(f) Your Committee recommends that each gubernatorial candidate be asked to pledge himself, as Governor-elect, to appoint an advisory committee to assist in the advance preparation of legislation for introduction in the next General Assembly, and to give the Indiana State Medical Association powerful representation thereon.

(g) It is also recommended that this advisory committee be charged with submitting to the General Assembly a suggested recodification of the laws governing commitment.

### 2. Non-medical Psychologists.

Your Committee condemns the assumption of responsibility for treating mentally ill patients by persons other than licensed physicians but approves the training of psychologists for service properly falling within the field of non-medical psychology. So-called clinical psychology should be practiced

only under the direction of a psychiatrist who is a duly licensed physician, or in a psychiatrically oriented and supervised treatment program.

Repeated efforts of psychologists to obtain enactment of legislation granting licensure have been opposed by committees for mental health of the I.S.M.A. and should continue to be opposed. Such licensure would imply in the public mind that psychologists are qualified to treat the sick and privileged to do so, and would therefore be in conflict with the medical practice act. However, an act providing for the *registration* of psychologists who are properly certified to have met certain minimal educational standards should be approved, in order to provide all concerned with some means of identifying persons adequately trained in non-medical psychology. Any bill for such an act should be carefully scrutinized to see that it does not imply certification *for* clinical practice, which would indeed be tantamount to licensure.

### 3. Mental Health in the Schools.

We recommend that efforts of the public schools to afford parents assistance in meeting special emotional disturbances of school children be approved and encouraged, provided that such services be placed under the direction of qualified psychiatrists responsible for the supervision of the work of non-medical psychologists, social workers, and nurses engaged in this program.

### 4. Private Practice by Institutions.

Your committee has noted with approval the tendency on the part of some public psychiatric institutions to establish out-patient departments for the follow-up care of furloughed or discharged in-patients who are unable to secure the services of a psychiatrist in private practice. However, the expansion of such out-patient departments for the servicing of patients who have never been charges of the institutions or who are able to command the services of a psychiatrist in private practice is to be condemned. Such expansion is in opposition to the economical operation of the institutions and tends inevitably toward socialization of medical practice.

Your Committee also disapproves of the treatment of persons well able to afford private psychiatric service by clinics operated by any State agency and maintained by State funds.

### 5. Authorization for Public Liaison.

It is suggested that this Committee for Mental Health, as appointed by the incoming President of the I.S.M.A. be authorized to make itself available to the Governor-elect or other elected representatives of the public for assisting in framing proposed mental health legislation and for interpret-

ing the views of the I.S.M.A. on mental health matters.

E. VERNON HAHN, M.D., *Chairman.*

MURRAY DEARMOND, M.D.

CARTER DUNSTONE, M.D.

LOUIS W. NIE, M.D.

JOHN H. HARE, M.D.

PHILIP B. REED, M.D.

## COMMITTEE ON MILITARY MANPOWER

Activities of the Military Manpower Committee during the past year have followed the policies determined at the organization meetings of the previous year. The only deviations have been such changes as have been required by instructions from the National Advisory Committee to Selective Service.

Registrants in Priority I and reservists in the same priority are a group who will all be ordered for induction or called to active duty by November. Deferments for essentiality are being reviewed. Availability of the names of returning physicians through the State Medical Association is expected by the National Committee to furnish replacements of Priority I registrants not as yet called.

During the year ending July 1, 32 doctors have been called to active duty from this state.

The registration figures obtained from the State Board of Medical Registration for this year as compared with last show a decrease of 33 physicians (4,133 in 1951 and 4,100 in 1952).

Two years of experience under the Doctors Draft has given us what may be the maximum call on Indiana doctors if military needs do not increase. From this time as many doctors should be returning to practice as are called.

There have been no changes in the number of doctors rejected for physical disqualifications.

Deferments for extreme hardship are rarely a problem and unless the Armed Services or Selective Service requests we cannot make recommendations.

Priority II availability and essentiality surveys are in progress as doctors in this category may, according to present estimate, be called to active duty during the coming year.

The processing by Selective Service of the records of Doctors in Priority III is now under way. In order to qualify for physical examination all doctors in Priority III have been classified as I-A. When the physical status of the registrant is determined further classification on a physical basis can be expected. Screening of Priority III phy-



sicians as to essentiality and availability will be carried out as with Priority I and II. With this group again the local Military Manpower Committee's recommendations will be sought. No calls for Priority III physicians are anticipated before Priority II category has been exhausted.

The Washington News Bulletin in the A. M. A. Journal contains all important up-to-the-minute news available on Military Manpower activities on a national basis. Indiana State Medical Association news letter and the Indiana State Medical Association news letter and the Indiana State Medical Association Journal also carry information as it is available.

Again it is emphasized that while recommendations of state and local committees may be made regarding essentiality the local draft boards have the right to accept or reject this advice. The same is true of the Armed Forces and those doctors who are in the Armed Forces Reserves.

JOHN E. OWEN, M.D., *Chairman*

CHARLES F. THOMPSON, M.D.

JOSEPH E. WALTHER, M.D.

HERMAN T. COMBS, M.D.

CARL G. MILLER, M.D.

H. M. ENGLISH, M.D.

GORDON A. THOMAS, M.D.

## COMMITTEE ON NECROLOGY

This committee is continuing its work in compiling the records as to the causes of death of the doctors in this state and it is published at as early a date as possible each year in the INDIANA STATE MEDICAL JOURNAL.

JAMES B. MAPLE, M.D., *Chairman*

E. B. JEWELL, M.D.

W. D. INLOW, M.D.

## COMMITTEE ON PHYSICIAN-HOSPITAL RELATIONSHIPS

The Committee on Physician-Hospital Relationships, during its second year, continued to press for a change in the insurance coverage for the professional services of anesthesiologists, radiologists and pathologists from Blue Cross to Blue Shield.

The program of education on this issue, as well as a drive for better understanding between the physicians, nurses and hospital administration was carried on by means of a bulletin issued several

times during the year and distributed with the ISMA "News Flashes."

Mutual Medical Insurance has initiated a pilot program in Northern Indiana for the coverage of radiologists; we think that this is a step in the right direction. The Indiana Roentgen Society and the Indiana State Society of Anesthesiologists have indicated that the majority of their members desire a change in the insurance coverage from Blue Cross to Blue Shield.

The Executive Secretary of Blue Cross, Guy W. Spring, was most cooperative in re-writing the Blue Cross letter that is sent out to all of their members who have received Blue Cross hospitalization benefits. This letter originally did not separate professional medical services from hospital services. The new letter that they are sending out separates professional medical services from the customary hospital services. We feel that this new letter now being sent out will help clarify in the public mind the fact that professional medical services are not to be confused with customary hospital services.

This committee recommends that the aims of the committee be continued.

Because this committee was originally formed to carry out the recommendations of the Hess Report, we wish to recommend that the Professional Services of Anesthesiologists, Radiologists and Pathologists, as well as the General Practice and Surgery sections, be represented on this committee.

WM. H. LANE, M.D., *Chairman*

LESTER D. BIBLER, M.D.

WM. C. WRIGHT, M.D.

HARRY PANDOLFO, M.D.

MAURICE V. KAHLER, M.D.

RUSSELL W. LAVENGOOD, M.D.

## COMMITTEE ON SCHOOL HEALTH AND PHYSICAL EDUCATION

Your committee has not met with any degree of regularity during the year, but believe we have accomplished much in bringing about a better spirit of cooperation between physicians, school administrators and teachers.

Following the conclusion of our state-wide conference last year regional meetings were held in all sections of the state during which time the state conference was carried to the community level and problems discussed for bringing before the next state meeting. These regional conferences were under the direction of the Indiana State Board of Health who consulted and sought the advice of your committee in conducting each of the programs.

So successful was the state-wide conference that another such meeting was being planned for September 23, 1952 at the Marott Hotel in Indianapolis. The 1952 conference will find two additional co-sponsors added to the list, namely the Indiana State Teachers Association and the Indiana High School Athletic Association. Anticipating a larger attendance this year, the committee worked out the following program for the day-long discussion:

1. Are Immunization and Physical Examinations School Health Problems?
2. Physician-Nurse and Teacher Cooperation in Classroom Observation.
3. Practical Method of Handling School Emergencies and Athletic Injuries.
4. What's Required in a Good Practical Screening Program?

The above subjects were to be handled by workshop groups and the entire assembly addressed by W. W. Bauer, M.D., Director of the Bureau of Health Education of the American Medical Association. The Governor, Honorable Henry F. Schricker, was to address the luncheon session.

Plans are already nearing completion for a series of regional meetings to again follow-up the state conference.

Your committee feels this activity is doing much to bring about a better understanding between the interested groups, in the field of school health programs. All have been enthusiastic in their support and their effort to make these meetings a success. We are hopeful that as time progresses, we shall see all working together as a team in the field of school health programs.

G. O. LARSON, M.D., *Chairman*.  
 JOSEPH H. CLEVINGER, M.D.  
 JOHN B. WESTFALL, M.D.  
 JOHN E. FISHER, M.D.  
 N. C. ISLER, M.D.  
 L. M. McNAUGHTON, M.D.  
 CLARENCE V. ROZELLE, M.D.

## COMMITTEE ON STATE FAIR

The State Fair Committee, as usual, had its exhibits at the west end of the State Board of Health Building on the Indianapolis fairgrounds during the Indiana State Fair August 28 through September 6, 1952. The background of this display consisted of two exhibits, "The Effects of Alcohol on the Human Body" as sponsored by the American Medical Association and the National Safety Council; and the other, entitled "You Can Lose

Weight Safely" by the A. M. A. These exhibits were augmented very helpfully by the Indiana State Police force which had in attendance a uniformed officer to show the use of the drunkometer and explain its use in ridding the public highways of drinking drivers. The attention-getter for the exhibit was, as usual, the taking of blood pressures of fair goers free of charge. This was done by four medical students, and was very popular, as in the past. Over 8,000 persons visited the exhibit and had their blood pressures taken. Those who stopped to see the exhibits were handed pamphlets on health information which were presented to the Committee by the American Medical Association for this purpose, and were distributed by members of the Indianapolis Medical Society Auxiliary.

The committee wishes to thank the following persons for their help in making this exhibit possible: Mr. James Waggner, executive secretary, Dr. L. E. Burney of the Indiana State Board of Health, Superintendent O'Neal of the Indiana State Police force and Mrs. Myron Nourse of the Indianapolis Medical Society Auxiliary.

MALCOLM O. SCAMAHORN, M.D., *Chairman*  
 WILLIAM D. PROVINCE, M.D.  
 LOWELL F. BEGGS, M.D.  
 MATHIAS S. MOUNT, M.D.  
 PHILIP HEDRICK, M.D.

## COMMITTEE ON TRAFFIC SAFETY

Our meetings and discussions have resulted in the following recommendations which we submitted to the Committee on Traffic Legislation of the State Legislature.

1. Revision of the present law compelling doctors, under heavy penalty, to report all epileptics, as such, which violates the right of privileged communication. Replacement of such law by one providing for the reporting of ANY "physical condition which renders the patient unfit for driving"; the exact diagnosis to be given only on demand and with permission of the patient.
2. Provide the Indiana State Police system with adequate personnel to administer and enforce the traffic laws and program, said increase to be accomplished as such personnel can be absorbed efficiently. We suggest increased co-operation between state, city and county traffic enforcement personnel so that better



and more efficient coordination be accomplished.

3. In addition to tax receipts, either evidence of non-cancellable insurance or a paid-up bond in the amount of \$10,000, said financial responsibility to cover the period of validity of the license before a car's license is issued. We believe this is the necessary step to insure financial liability in case of accident, a part of the present law which is not too well complied with.
4. We wish to commend the high school drivers' training program, of class room instruction and behind the wheel experience, and recommend that this be extended and enlarged as quickly as it is efficiently possible over the state.
5. We recommend continued intensive study and use of highway signs, stop lights, including 4-way stops at intersections. We recommend this study particularly at intersections of high accident rate.
6. We recommend that a study on speed limit be made with a suggestion of 60 miles per hour during the day and 50 miles per hour at night. Also a study of possible legislation regarding the minimal speed on arterial highways.
7. We believe some study should be made regarding the use of drugs (either of stimulative or sedative nature) while driving. We are of the opinion that the use of such drugs is a danger because of their interference of the normal reflexes and judgment of the driver.
8. We recommend a study be made regarding liability in regard to bicycle riders on arterial highways. We discussed the increased danger and suggest some regulation similar to those regarding pedestrian traffic on arterial highways.
9. We encourage the Red Cross First Aid program and training of more personnel to give first aid, including ambulance drivers, police, filling station operators, schoolteachers, etc. We also suggest establishment of more first aid stations especially along busy arterial highways.

G. T. BOWERS, M.D., *Chairman*  
 RALPH C. EADES, M.D.  
 DAVID HADLEY, M.D.  
 O. E. WILSON, M.D.  
 C. PHILLIP FOX, M.D.

## COMMITTEE ON TUBERCULOSIS

No report.

## COMMITTEE ON VENEREAL DISEASE

Nothing has been brought to the attention of the Venereal Disease Committee during the past year; consequently, there has been no occasion for any meeting, and there is no report.

So far as your Chairman is able to determine, everything is running smoothly in Venereal Disease Control.

MINOR MILLER, M.D., *Chairman*  
 T. D. RHODES, M.D.  
 E. O. NAY, M.D.  
 PAUL P. BAILEY, M.D.  
 JAMES BALCH, M.D.

## COMMITTEE ON VETERANS AFFAIRS AND REHABILITATION

The Committee on Veterans Affairs and Rehabilitation had one called meeting April 6, 1952. This meeting was called to consider the Bibler resolution which was approved and later passed by the interim session of House of Delegates.

A renewal of fee schedule contract was signed for year 1952 and 1953. There were no marked changes in the fee schedule.

One more called meeting is anticipated before the October session of I.S.M.A. to consider the request of the A.M.A. for a study of:

- (a) Medical and hospital benefits for veterans with non-service connected disabilities.
- (b) Medical and hospital benefits for dependents of service personnel.
- (c) Transfer of seriously disabled service personnel from service hospitals to Veterans Administration installations.

We also plan to discuss the Tennessee resolution at our called meeting.

WM. H. GARNER, M.D., *Chairman*  
 KEITH RUDDALL, M.D.  
 JOHN C. CARNEY, M.D.  
 GEORGE W. WAGONER, M.D.  
 JOSEPH T. FARRELL, M.D.  
 JACK L. EISAMAN, M.D.

## THE JOURNAL

During the past year *THE JOURNAL* has continued on a sound financial basis, as evidenced by the report of the business manager.

Scientific articles received by contribution and from the program of the annual session have not been in sufficient number to fulfill our needs. The deficiency has been cured by soliciting papers, some of which have been outstanding. Our supply of unpublished papers is now at a comfortable level. We are able to publish papers soon after their acceptance. However, to avoid decreasing the supply to a dangerous level, it will be desirable for *THE JOURNAL* to receive several dozen well written papers during the coming year.

Physically *THE JOURNAL* has been improved by the adoption of a larger type size, and an improved format. The use of well chosen illustrations for the scientific content has been encouraged by liberalizing the rules which govern the authors' costs for cuts.

The legislative news inserts, printed on colored stock, have been featured during the last few months. This feature is on trial. Continuance or discontinuance will depend upon its reception by the membership.

A special subscription rate of \$3.00 per year has been authorized for medical students, interns and residents. This rate was established at the request of the Student A.M.A., with a view to extending the advantages of *THE JOURNAL*, particularly to the medical students.

We have under consideration a plan to publish the home and office telephone numbers of all members in the Year Book roster. Such a service would be of value in supplying telephone numbers for long distance calls within the state. However, the addition of telephone numbers to the roster would require considerable painstaking clerical work and would be expensive. If a large number of members could be expected to use the roster for telephone number information, it will be work and money well spent. Further discussion is needed in order to reach a decision.

The Council is enlarging the editorial staff of *THE JOURNAL* and during this Annual Session will elect three additional Associate Editors. The larger staff will be more representative of the entire state, and will allow more detailed work on many features of *THE JOURNAL*.

FRANK B. RAMSEY, M.D., *Editor*.

## AMENDMENT TO CONSTITUTION TO BE VOTED ON AT THE INDIANAPOLIS SESSION, 1952

At the 1951 annual session in Indianapolis the House of Delegates adopted the following resolution, which will abolish the office of alternate councilor:

"RESOLVED, That Article IX of the Constitution of the Indiana State Medical Association be amended by striking out Section 5 thereof, and by renumbering the remaining sections accordingly."

Section 5, which the above resolution deletes, reads as follows:

"Sec. 5.—Each Councilor district shall elect an alternate Councilor whose term of office shall be the same as the Councilor, namely three years. The alternate Councilor shall be elected in a year during which there is no Councilor elected.

"The duties of the alternate Councilor shall be:

"1. To represent the Councilor district in the absence of the regularly elected Councilor.

"2. To vote only in the absence of the regularly elected Councilor either in the House of Delegates or in Council meetings where he represents the regularly elected Councilor.

"3. The alternate Councilor shall not have the power of discussion if the regularly elected Councilor is present."

This amendment was printed in the December, 1951, *JOURNAL*, and is reprinted here to conform with Article XIV of the Constitution which states that "The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates present at any Annual Convention, provided that such amendment shall have been presented in open meeting at the previous Annual Convention, and that it shall have been published twice during the year in *THE JOURNAL* of this Association."



**HOUSE OF DELEGATES**  
**INDIANA STATE MEDICAL ASSOCIATION**  
**INDIANAPOLIS, INDIANA**  
**OCTOBER 28, 29 AND 30, 1952**

Delegate	Alternate	Delegate	Alternate
<b>ADAMS</b>		<b>DELAWARE-BLACKFORD</b>	
James M. Burk, Decatur	Norman E. Beaver, Berne	Kemper Venis, Muncie	
		Clay Ball, Muncie	
		Dean Jackson,	
		Hartford City	
<b>ALLEN</b>		<b>DUBOIS</b>	
H. Vaughn Scott,	H. G. Haffner,	M. C. Heck, Jasper	Charles H. Klammer, Jasper
Fort Wayne	Fort Wayne		
W. C. Wright,	R. H. Stauffer,	<b>ELKHART</b>	
Fort Wayne	Fort Wayne	Burton Kintner, Elkhart	Leon Chandler,
Elmer C. Singer,	Herbert M. Senseny,	S. T. Miller, Elkhart	Millersburg
Fort Wayne	Fort Wayne	Jack Hannah, Wakarusa	
M. E. Glock,	Gerald H. Somers,		
Fort Wayne	Fort Wayne		
<b>BARTHOLOMEW-BROWN</b>		<b>FAYETTE-FRANKLIN</b>	
L. F. Beggs, Columbus	J. E. Dudding, Hope	H. N. Smith, Brookville	Perry Seal, Brookville
K. D. Schneider, Nashville		J. M. Lockhart,	F. B. Mountain,
		Connersville	Connersville
<b>BENTON</b>		<b>FLOYD</b>	
V. L. Turley, Fowler	Charles Smith, Otterbein	John M. Paris, New Albany	C. E. Briscoe, New Albany
<b>BOONE</b>		<b>FOUNTAIN-WARREN</b>	
Harvey D. Lovett,	Clarence Kern, Lebanon	Lee Maris, Attica	Lowell Stephens,
Whitestown		James Crain, Williamsport	Covington
			Carl Nelson, West Lebanon
<b>CARROLL</b>		<b>FULTON</b>	
Max Adams, Flora	Thomas C. Brown, Delphi	A. E. Stinson, Rochester	John Glackman, Rochester
<b>CASS</b>		<b>GIBSON</b>	
E. B. Jewell, Logansport	John Davis, Logansport	Virgil McCarty, Princeton	H. G. Petitjean, Haubstadt
<b>CLARK</b>		<b>GRANT</b>	
Joel Carney, Jeffersonville	William Clark,	Max Long, Marion	J. P. Powell, Marion
	Jeffersonville		
<b>CLAY</b>		<b>GREENE</b>	
John M. Palm, Brazil	Charles Moon, Centerpoint	John Woner, Linton	Asa Fender, Worthington
<b>CLINTON</b>		<b>HAMILTON</b>	
Frank Beardsley,	Robert Hedgecock,	John S. Hash, Noblesville	Sam Campbell, Noblesville
Frankfort	Frankfort		
<b>DAVIESS-MARTIN</b>		<b>HANCOCK</b>	
Robert Rang, Washington	Arthur Blazey, Washington	J. L. Allen, Greenfield	R. E. Kinneman,
			Greenfield
<b>DEARBORN-OHIO</b>		<b>HARRISON-CRAWFORD</b>	
Gordon S. Fessler,	Charles N. Manley,	W. E. Amy, Corydon	Carl Dillman, Corydon
Rising Sun	Rising Sun		
J. K. Jackson, Aurora	M. J. McNeely, Dillsboro	<b>HENDRICKS</b>	
<b>DECATUR</b>		O. T. Scamahorn, Pittsboro	J. C. Stafford, Plainfield
W. C. Callaghan, Decatur	William T. Sallee,	<b>HENRY</b>	
	Greensburg	W. M. Stout, New Castle	L. C. Marshall, Mt. Summit
<b>DEKALB</b>		<b>HOWARD</b>	
R. P. Reynolds, Garrett	F. B. Kantzer, Butler	Richard P. Good, Kokomo	Robert Evans, Russiaville
		<b>HUNTINGTON</b>	
		G. M. Nie, Huntington	Thomas James, Huntington
		<b>JACKSON</b>	
		Jack E. Shields,	W. H. Shortridge, Seymour
		Brownstown	
		<b>JASPER-NEWTON</b>	
		W. G. Tippenger, Brook	
		Frank G. Sink, Remington	

Delegate	Alternate	Delegate	Alternate
<b>JAY</b>		<b>MARSHALL</b>	
<b>JEFFERSON-SWITZERLAND</b>		A. A. Thompson, Tyner	M. O. Klinger, Plymouth
Robert O. Zink, Madison	S. A. Whitsitt, Madison	<b>MIAMI</b>	
L. H. Bear, Vevay	Noel Graves, Vevay	S. D. Malouf, Peru	E. E. Shrock, Amboy
<b>JENNINGS</b>		<b>MONTGOMERY</b>	
D. W. Matthews, North Vernon	B. W. Thayer, North Vernon	J. M. Kirtley, Crawfordsville	F. N. Daugherty, Crawfordsville
<b>JOHNSON</b>		<b>MORGAN</b>	
O. A. Province, Franklin	Harry Murphy, Franklin	R. W. Van Bokkelen, Mooresville	B. nard Karpel, Mooresville
<b>KNOX</b>		<b>NOBLE</b>	
Paul Arbogast, Vincennes	Herbert O. Chattin, Vincennes	J. R. Nash, Albion	Robert Bryan, Kendallville
<b>KOSCIUSKO</b>		<b>ORANGE</b>	
Winton Thomas, Warsaw		Keith Hammond, Paoli	N. E. Kseric, French Lick
<b>LAGRANGE</b>		<b>OWEN-MONROE</b>	
Philip Yunker, Howe	Kenneth Lehman, Topeka	William C. Reed, Bloomington	R. E. Buckingham, Bloomington
<b>LAKE</b>		Oran E. Kay, Spencer	C. E. Stouder, Gosport
Harry R. Stimson, Gary	Michael Shellhouse, Gary	<b>PARKE-VERMILLION</b>	
Ray Elledge, Hammond	F. F. Premuda, Hammond	W. D. Britton, Montezuma	R. S. Bloomer, Rockville
R. J. Modjeski, Hammond	O. L. Marks, East Chicago	Paul Casebeer, Clinton	Fred Evans, Clinton
J. P. Vye, Gary	R. A. Elliott, Gary	<b>PERRY</b>	
S. J. Petronella, East Chicago	E. L. Schaible, Gary	D. L. Lashley, Tell City	N. A. James, Tell City
W. R. Troutwine, Crown Point	J. P. Birdzell, Crown Point	<b>PIKE</b>	
<b>LAPORTE</b>		M. H. Omstead, Petersburg	J. L. Higgins, Petersburg
G. O. Larson, LaPorte	V. F. Kling, Michigan City	<b>PORTER</b>	
<b>LAWRENCE</b>		Ralph C. Eades, Valparaiso	John R. Frank, Valparaiso
Donald M. Kerr, Bedford	L. E. Benham, Bedford	<b>POSEY</b>	
<b>MADISON</b>		Wm. B. Challman, Mount Vernon	Paul Boren, Poseyville
P. T. Lamey, Anderson	J. L. Doenges, Anderson	<b>PULASKI</b>	
G. B. Wilder, Anderson	Ralph Ploughe, Elwood	William R. Thompson, Winamac	Charles A. Yale, Winamac
<b>MARION</b>		<b>PUTNAM</b>	
Howard W. Beaver, Indianapolis	O. H. Bakemeier, Indianapolis	George T. Tennis, Greencastle	Richard Veach, Bainbridge
Lester D. Bibler, Indianapolis	Edward F. Bloemker, Indianapolis	<b>RANDOLPH</b>	
Floyd A. Boyer, Indianapolis	Wendell E. Brown, Indianapolis	R. M. Potter, Ridgeville	Arvin Henderson, Ridgeville
James W. Denny, Indianapolis	Paul K. Cullen, Indianapolis	<b>RIPLEY</b>	
Ralph V. Everly, Indianapolis	Forrest L. Denny, Indianapolis	G. S. Row, Osgood	L. G. Hunter, Milan
W. D. Gatch, Indianapolis	W. Stanley Garner, Indianapolis	<b>RUSH</b>	
Lester H. Hoyt, Indianapolis	Jacob E. Gillespie, Indianapolis	Davis W. Ellis, Rushville	Robt. B. Johnson, Rushville
Clifford H. Jinks, Indianapolis	Thomas A. Hanna Indianapolis	<b>ST. JOSEPH</b>	
Maurice V. Kahfer, Indianapolis	Jerome E. Holman, Sr., Indianapolis	D. D. Stiver, South Bend	J. F. Murphy, South Bend
D. S. Megenhardt Indianapolis	George F. Lawler, Indianapolis	A. S. Giordano, South Bend	Donald Grillo, South Bend
Earl W. Mericle, Indianapolis	B. J. Matthews, Indianapolis	M. I. Hewitt, South Bend	C. S. Culbertson, South Bend
Paul Merrell, Indianapolis	Robert W. McTurnan, Indianapolis	F. R. N. Carter, South Bend	George Gates, South Bend
T. V. Petranoff, Indianapolis	William H. Norman, Indianapolis	<b>SCOTT</b>	
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The technical exhibitors at our annual convention contribute a major share of the expense of this meeting. Show your appreciation of their support by utilizing the intermissions which have been arranged in the scientific sessions to visit with them.

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Thurman B. Rice, M.D., Indianapolis

J. Frank Maurer, M.D., Brazil

C. Toney Dutchess, M.D., Galveston

Lounge Room, Murat Temple

**1. Nasal Injuries—Relationship to Nasal Physiology.**

Carl B. Spath, Jr., M.D., Indianapolis  
Dr. Maurice H. Cottle, Chicago  
Sidney S. Aronson, M.D., Indianapolis  
David E. Brown, M.D., Indianapolis  
Raleigh E. Lingeman, M.D., Indianapolis  
Lewis E. Morrison, M.D., Indianapolis  
J. Lawrence Sims, M.D., Indianapolis  
Alan L. Sparks, M.D., Indianapolis  
Sidney L. Stevens, M.D., Indianapolis  
John R. Swan, M.D., Indianapolis

**2. Cutaneous Manifestations of Diseases.**

(Diabetes, Xanthoma, L. E., etc.)  
S. R. Mercer, M.D., Fort Wayne

**3. I Beat Tuberculosis.**

Indiana Tuberculosis Association,  
Chester D. Kelly, Executive Secretary  
130 E. Washington Street, Indianapolis

**4. Help in Preparing Low Sodium Diets.**

Indiana Heart Foundation,  
T. A. Kleckner, Executive Director,  
1101 West Tenth Street, Indianapolis.

**5. Advantages of Electrocardiography during Surgery.**

Jack L. Elsaman, M.D.  
Harold D. Caylor, M.D.  
Charles E. Jackson, M.D.,  
303 South Main Street, Bluffton

**6. The Treatment of Symptoms.**

Milton L. Bankoff, M.D.,  
1412 Washington Street,  
Michigan City, Indiana

**7. Management of Poliomyelitis Patients with Respiratory Difficulty.**

Hart E. VanRiper, M.D., Medical Director,  
National Foundation for Infantile Paralysis,  
120 Broadway, New York 5, New York.

**8. Indiana Pharmaceutical Association.**

H. George DeKay, Chairman,  
Professional Relations,  
Indiana Pharmaceutical Association,  
Purdue University,  
Lafayette, Indiana.

**9. Recruitment for Students of Medical Technology.**

Indiana Society of Medical Technologists and  
Laboratory Technicians, Inc.

**10. Vital Statistics.**

Indiana State Board of Health.

**11. Grain Itch.**

Boynton H. Booth and Roland W. Jones,  
General Hospital, Indianapolis.

Grain itch or infestation by the mite *Pediculoides ventricosus* was present in epidemic proportions in Indiana during the harvest seasons of 1950, 1951 and 1952. Through exposure to infected wheat straw hundreds of individuals including Indiana State Fair employees, exhibitors, visitors and straw-board factory workers, farmers and others were affected. The basic reason for the occurrence of this epidemic, the epidemiology of the mite, its geographic distribution, an account of the previous epidemics and resume of control and therapeutic measures are presented. This exhibit was awarded an honorable mention during the meeting of the AMA in June of this year.

# DATA FROM PREVIOUS SESSIONS

Year	Session	Place	Registration	Year	Session	Place	Registration
1908	59th	French Lick	312	1930	81st	Fort Wayne	1,115
1909	60th	Terre Haute	421	1931	82nd	Indianapolis	1,033
1910	61st	Fort Wayne	450	1932	83rd	Michigan City	904
1911	62nd	Indianapolis	748	1933	84th	French Lick	637
1912	63rd	Indianapolis	590	1934	85th	Indianapolis	1,814
1913	64th	West Baden	312	1935	86th	Gary	1,011
1914	65th	Lafayette	527	1936	87th	South Bend	1,150
1915	66th	Indianapolis	646	1937	88th	French Lick	1,154
1916	67th	Fort Wayne	381	1938	89th	Indianapolis	1,751
1917	68th	Evansville	270	1939	90th	Fort Wayne	1,332
1918	69th	Indianapolis	388	1940	91st	French Lick	1,064
1919	70th	Indianapolis	---	1941	92nd	Indianapolis	1,890
1920	71st	South Bend	421	1942	93rd	French Lick	706
1921	72nd	Indianapolis	550	1943	94th	Indianapolis	1,323
1922	73rd	Muncie	522	1944	95th	Indianapolis	1,584
1923	74th	Terre Haute	823	1945	96th	French Lick	922
1924	75th	Indianapolis	1,012	1946	97th	Indianapolis	2,240
1925	76th	Marion	800	1947	98th	French Lick	1,618
1926	77th	West Baden	900	1948	99th	Indianapolis	2,681
1927	78th	Indianapolis	1,500	1949	100th	Indianapolis	3,371
1928	79th	Gary	892	1950	101st	French Lick	1,610
1929	80th	Evansville	814	1951	102nd	Indianapolis	2,241

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 F. G. Sink, M.D.  
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 Marcella Modisett, M.D.  
 William A. Shuck, M.D.  
 Anna Goss Turner, M.D.  
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 W. D. Province, M.D.  
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 George A. Tiley, M.D.  
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 William Schulze, M.D.  
 John A. Scudder, M.D.  
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 Frederic Spencer, M.D.  
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 Hugh S. Ramsey, M.D.  
 William C. Reed, M.D.  
 Ben R. Ross, M.D.  
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 R. O. Kennedy, M.D.  
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 George Plain, M.D.  
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 Thomas P. Potter, M.D.  
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 Eli Rubens, M.D.  
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 Merle C. Sharp, M.D.  
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 R. J. Rossow, M.D.  
 H. C. Ruddick, M.D.  
 W. D. Snively, Jr., M.D.  
 D. C. Tweedall, M.D.  
 J. W. Visher, M.D.  
 Henry G. Weiss, M.D.  
 Thomas Wesson, M.D.  
 Kenneth Wilhelmus, M.D.  
 G. W. Willison, M.D.  
 John D. Wilson, M.D.  
 Shelby W. Wishart, M.D.  
 W. P. Woods, M.D.  
 Harold Zimmerman, M.D.

**VIGO COUNTY**

Helen B. Barnes, M.D.  
 L. L. Blum, M.D.  
 Robert R. Brown, M.D.  
 A. W. Cavins, M.D.  
 Eugen Eisenlohr, M.D.  
 D. A. Gerrish, M.D.  
 Hubert T. Goodman, M.D.  
 Paul E. Humphrey, M.D.  
 R. N. Kabel, M.D.  
 William W. Kriebel, M.D.  
 Noel S. McBride, M.D.  
 A. M. Mitchell, M.D.  
 G. G. Musselman, M.D.  
 E. O. Nay, M.D.  
 Louis G. Neudorff, M.D.  
 Roy V. Pearce, M.D.  
 J. V. Richart, M.D.  
 Burton E. Scherb, M.D.  
 M. C. Topping, M.D.  
 E. C. Voges, M.D.

**WABASH COUNTY**

O. G. Brubaker, M.D.  
 J. G. Kidd, M.D.  
 G. W. Seward, M.D.  
 J. T. Steffen, M.D.  
 James L. Walker, M.D.

**WARRICK COUNTY**

W. C. Stover, M.D.

**WAYNE-UNION COUNTIES**

Frank B. Adney, M.D.  
 H. E. Allen, M.D.  
 R. T. Allen, M.D.  
 Paul W. Blossom, M.D.  
 Frank H. Coble, M.D.  
 Leon T. Cox, M.D.  
 Rolfe A. Heck, M.D.  
 D. R. Hutchison, M.D.  
 George M. Johnson, M.D.  
 Glen Ward Lee, M.D.  
 Charles H. Loomis, M.D.  
 Russell L. Malcolm, M.D.  
 E. J. Meredith, M.D.  
 Harry P. Ross, M.D.  
 P. W. Runge, M.D.  
 Morris C. Snyder, M.D.  
 Will A. Thompson, M.D.  
 Horace Wanninger, M.D.  
 Francis B. Warrick, M.D.  
 Arthur J. Whallon, M.D.  
 M. W. Yencer, M.D.

**WELLS COUNTY**

H. B. Annis, M.D.  
 C. J. Aucreman, M.D.  
 Harold D. Caylor, M.D.  
 Truman E. Caylor, M.D.  
 Robert G. Cook, M.D.  
 T. O. Dorrance, M.D.

Jack L. Eisaman, M.D.  
 Charles E. Jackson, M.D.  
 Robert L. Johnston, M.D.  
 S. Bruce Kephart, M.D.  
 Allen C. Nickel, M.D.  
 R. M. Sherman, M.D.  
 Pierre C. Talbert, M.D.  
 Wallace S. Tirman, M.D.  
 Richard P. Yoder, M.D.

**WHITE COUNTY**

S. E. McClure, M.D.  
 Warren V. Morris, M.D.

**WHITLEY COUNTY**

John L. Langohr, M.D.

**OUT OF STATE**

1st Lt. Robert D. Arnold, M.D.,  
 Tinker AFB, Oklahoma  
 J. Colin Elliott, M.D., Buchanan,  
 Mich.  
 John E. Graf, M.D., Chicago, Illinois  
 Laurence E. Jewett, M.D., Excelsior  
 Springs, Missouri  
 T. O. Middleton, M.D., Ft. Benning,  
 Ga.  
 D. H. Murray, M.D., Napa, California  
 Sydney S. Norwick, M.D., San Lo-  
 renzo, California

**MISCELLANEOUS**

Elkhart County Medical Society  
 Indiana Academy of General Prac-  
 tice  
 Indianapolis Medical Society  
 Kosciusko County Medical Society  
 Tippecanoe County Medical Society  
 Whitley County Medical Society

The **American Heart Association** will conduct a regional meeting in the Warren Hotel, Indianapolis, on October 9 and 10 with representatives from Indiana, Illinois, Kentucky, Michigan, Ohio and Wisconsin in attendance. The **Indiana Heart Foundation** will hold its annual meeting on Sunday, October 26, in Rice Auditorium, Indiana State Board of Health Building, Indianapolis. Dr. Charles D. Marple, medical director of the American Heart Association, will speak.



# TECHNICAL EXHIBITORS

**ABBOTT LABORATORIES**  
NORTH CHICAGO, ILL.

## BOOTH 39

SUCARYL, the new non-caloric sweetener which is stable to heat and leaves no bitter aftertaste in ordinary use, will be exhibited by Abbott Laboratories along with other outstanding preparations.

**AKRON SURGICAL HOUSE, INC.**  
217-223 NORTH PENNSYLVANIA STREET  
INDIANAPOLIS 4, INDIANA

## BOOTH 24

A visit to our booth will show you a complete line of equipment and supplies for your office. Hamilton furniture will be featured in the new Ivorytone finish. The Colortone finishing process brings a completely new concept of beauty and color harmony to the examining room. Other finishes include coral-tone, greentone and bluetone.

**A. S. ALOE COMPANY**  
1831 OLIVE ST., ST. LOUIS 3, MO.

## BOOTH 33

Visit booth No. 33 where the Aloe representative will show you a cross section of the complete line of physicians' equipment and supplies carried by the A. S. Aloe Company. Highlighted will be New Model Steeline—tomorrow's treatment room furniture today—featuring the body contour table top, magnetic door catches and advanced design all in new decorators' colors.

**AMERICAN HOSPITAL SUPPLY CORPORATION**  
2020 RIDGE AVENUE  
EVANSTON, ILLINOIS

## BOOTH 36

American Hospital Supply Corporation will exhibit Baxter Intravenous Solutions, including Travert, the new invert sugar solution providing twice the calories as dextrose in the same infusion time; Baxter Blood Transfusion and Plasma equipment, together with the complete line of Baxter expendable accessories for the intravenous solutions and blood and plasma bottles.

**AMES COMPANY, INC.**  
ELKHART, INDIANA

## BOOTH 54

DECHOLIN SODIUM and DECHOLIN tablets will be featured at the Ames display. DIAGNOSTIC KIT, including CLINITEST, ACETEST, BUMINTEST, and HEMATEST, plus necessary equipment, will be demonstrated.

**ARNAR-STONE LABORATORIES, INC.**  
1316 SHERMAN AVE., EVANSTON, ILL.

## BOOTH 104

You are invited to attend the Americaine exhibit where our representatives will be pleased to discuss with you Americaine Topical Anesthetics containing 20% dissolved benzocaine. This 20% dissolved benzocaine is available in ointment and liquid form, and is combined with chlorophyll in the Americaine with chlorophyll preparation.

Our representative will be happy to show you the new Americaine Aerosol Dispenser, also containing the 20% dissolved benzocaine.

Ask for demonstration of the Lelectron-o-Scope, an electronic stethoscope which amplifies body sounds as much as 50 times.

**AYERST, McKENNA & HARRISON, LTD.**  
22 EAST 40TH ST., NEW YORK 16, N. Y.

## BOOTH 26

Physicians attending this meeting are invited to visit the Ayerst booth. In the Ayerst display, special attention is called to "Premarin." Representatives are on hand to discuss any items of our manufacture.

**BABY DEVELOPMENT CLINIC**  
600 S. MICHIGAN AVENUE  
CHICAGO 5, ILLINOIS

## BOOTH 15

BABY DEVELOPMENT CLINIC presents psychological and emotional aspects of early feeding in visual as well as printed form. Ideal for use of doctors, nurses as well as teachers, and others who are in contact with expectant parents, medical students or nurses in training.

MATERNITY COUNSELLING SERVICE . . . a courtesy service available to doctors for their maternity patients . . . relieves doctors of discussing layette needs and other preparations for home and baby. No charge or obligation to doctor or patients. Supported by firms included in exhibit.

**BAKER BROTHERS, INC.**  
233 NORTH DELAWARE STREET  
INDIANAPOLIS

## BOOTHS 66 and 67

Baker Brothers will have a display of products in Booths 66 and 67. The firm sells and maintains complete rental service for sickroom supplies, invalid equipment for home and hospital. Items to be displayed during the Association convention include Hospital Beds—Everest and Jennings Folding Wheel Chairs—Oxygen Equipment—Invalid Lifts and many other items.

Our company wishes to express its appreciation for your past consideration and cooperation. We will continue to give the best possible service in our community.

**THE BAKER LABORATORIES, INC.****4614 PROSPECT AVENUE****CLEVELAND 3, OHIO****BOOTH 53**

Baker's Modified Milk (Carbohydrate added) and Varamel (no Carbohydrate added) are made especially for infant feeding, from Grade A milk (U. S. Public Health Service Milk Code), which has been modified by replacement of the milk fat with animal and vegetable oils and by the addition of Vitamins and iron.

**BARD-PARKER COMPANY, INC.****DANBURY, CONN.****BOOTH 19**

Shown below are the products we plan to exhibit: Bard-Parker "Rib-Back" surgical blades—the utmost in cutting efficiency and blade economy; B-P handles of various types; instrument containers and transfer forceps units; The Reese Dermatome—for simpler, accurate splitskin grafts with the Dermatape technique. Truly a remarkable instrument.

**BILHUBER-KNOLL CORP.****337 CRANE STREET, ORANGE, NEW JERSEY****BOOTH 60**

Bilhuber-Knoll Corp., Booth No. 60, presents the latest developments in their medicinal chemicals and products:

Bromural—Daytime Sedative—Mild Hypnotic.

Dilaudid—Analgesic—Cough Sedative.

Metrazol—Central Depression—Senile Confusion.

Theocalcin—Cardiotonic—Diuretic.

Your visits and discussions will be welcomed.

**THE BOWMAN BROS. DRUG COMPANY****119 SCHROYER AVE. S. W., CANTON 2, OHIO****BOOTH 46**

The Bowman Bros. Drug Company has conducted an Ethical Pharmaceutical and Surgical Supply Business in the Midwest during the past half-century.

Our constant aim has been to supply the Profession with the Ethical pharmaceuticals desired. In addition to this, we have constantly been endeavoring to improve our Professional service through our three Service Centers located in Canton, Akron and Lima, Ohio.

We serve the state of Indiana from our Lima, Ohio Service Center.

Our exhibit will feature our Council Accepted Aminophylline preparations and our Council Accepted Vitamin preparations in addition to many NNR products.

The exhibit will be in charge of Mr. Wayne High, our Lima Service Center manager.

**BROOKS APPLIANCE COMPANY****5 N. WABASH AVENUE****CHICAGO 2, ILLINOIS****BOOTH 81**

The Brooks Appliance Company will exhibit and describe in detail the technique of applying the combination pressure bandages. The moist medicated Primer plus the Elastic Adhesive Dalzoflex which are used in treating leg ulcers and phlebitis.

Elastic Stockings, The NuLast Elastic Crepe Bandages and Surgical Instruments will also be displayed.

**BROWN & WILLIAMSON TOBACCO CORP.****1600 WEST HILL STREET,****LOUISVILLE 1, KENTUCKY****BOOTH 16 and 26**

The Brown & Williamson Tobacco Corporation cordially invites members and guests of the Indiana State Medical Association to visit the separate exhibits of KOOL (mildly mentholated) and VICEROY (filter tip) Cigarettes, two brands of particular interest to the medical profession. Souvenirs and informative literature will be presented to members and guests who register at the KOOL and VICEROY exhibits.

**BURROUGHS WELLCOME & CO., INC.****TUCKAHOE, NEW YORK****BOOTH 6**

Burroughs Wellcome will feature 'AEROSPORIN' sulfate (Polymyxin B Sulfate), a new antibiotic, which is effective against *Pseudomonas aeruginosa*, and also destroys most other gram-negative bacilli.

**CAMEL CIGARETTES****ONE PERSHING SQUARE****NEW YORK 17, NEW YORK****BOOTH 27**

CAMEL Cigarettes will mark your initials on an attractive plastic cigarette case filled with a package of those mild, flavorful CAMELS. This exhibit features a display of some of the tobaccos used in blending this famous cigarette which leads all other brands by many billions.

**CAMPBELL ASSOCIATES****515 RACE STREET, CINCINNATI 2, OHIO****BOOTH 89**

Campbell Associates will display a complete line of both imported and American made surgical instruments.



**THE CENTRAL PHARMACAL COMPANY  
SEYMOUR, INDIANA**

**BOOTH 62**

Our exhibit will feature two groups of original products; namely, the Synophylate and Trisulfazine products.

Synophylate, or Theophylline-Sodium Glycinate, offers many advantages over other Theophylline compounds, including low tendency to gastric irritation which permits high oral dosage with minimal risk of unpleasant reactions and ready absorption that brings about rapid clinical effect.

The Trisulfazine products offer an increased margin of safety in sulfa medication, plus rapid absorption and prolonged action.

**CHICAGO PHARMACAL COMPANY  
5547 N. RAVENSWOOD AVE., CHICAGO**

**BOOTH 28**

The Chicago Pharmacal Company (Chimedic), manufacturers of fine pharmaceuticals for over half a century, exhibit their well known quality line of Council-accepted products. Literature and samples of the many available dosage forms of a-Estradiol, Calcium Levulinate, Digitoxin, and Diethylstilbestrol are available to physicians attending the convention. We welcome your inspection.

**CHILCOTT LABORATORIES, INC.  
MORRIS PLAINS, NEW JERSEY**

**BOOTH 100**

For management of hypertension: Latest literature on clinical experience with Methium includes complete data about dosage schedules and control of side effects—For prophylaxis in angina pectoris: A complete clinical review of Peritrate, including research data and published clinical reports is available—For simplified, fast, accurate prothrombin determination: A compilation of published reports dealing with the control of oral anticoagulant therapy with Simplastin and laboratory studies of this quickly prepared thromboplastin extract are ready for your inspection.

**CIBA PHARMACEUTICAL PRODUCTS, INC.  
SUMMIT, NEW JERSEY**

**BOOTH 43**

The Ciba exhibit will feature APRESOLINE, a phthalazine derivative which is an orally effective and relatively safe therapy in hypertension of diverse etiology.

Representatives in attendance will be very glad to discuss and to provide literature on this and other Ciba products.

**THE COCA-COLA COMPANY  
ATLANTA 1, GEORGIA**

**BOOTH 35**

Ice cold Coca-Cola served through the cooperation and courtesy of the Indianapolis Coca-Cola Bottling Company and The Coca-Cola Company.

**CURTIS & FRENCH, INC.  
1108 NORTH PENNSYLVANIA STREET,  
INDIANAPOLIS 2, INDIANA**

**BOOTHS 101 AND 102**

The Curtis & French, Inc., organization expects to show new items of interest in equipment, instruments and scientific apparatus. The entire sales force will be in attendance waiting to serve the profession.

**DAIRY COUNCIL  
SOUTH BEND — INDIANAPOLIS  
EVANSVILLE — FORT WAYNE  
UNITS OF NATIONAL DAIRY COUNCIL**

**BOOTH 90**

You are cordially invited to visit our booth for a cold refreshing drink of milk. Dairy Council health education materials, including the new "Weight Reduction" leaflet, will also be on display.

**DICK X-RAY COMPANY, INC.  
443 N. PENNSYLVANIA ST., INDIANAPOLIS AND  
3976 OLIVE STREET, ST. LOUIS, MO.**

**BOOTH 105**

The Dick X-Ray Company will have on display:

Liebel-Flarsheim diathermy  
Cambridge EKG  
Jones BMR units  
Westinghouse x-ray accessories  
Burdick constrictor  
Liebel-Flarsheim Bovie units

**DISABILITY INCOME INSURANCE COMPANY  
130 E. WASHINGTON ST., INDIANAPOLIS 4, IND.**

**BOOTH 103**

All physicians having questions or desiring information on their accident and health insurance will be welcomed at Booth 103. This is your opportunity to obtain facts without being importuned to buy. Descriptive literature will be available—without discussion if you prefer—on our non-cancellable, guaranteed renewable, level-premium disability income policies recommended by life underwriters in your community.

**EDISON CLINICAL RECORDING  
VAN AUSDALE & FARRAR  
7 W. TENTH ST., INDIANAPOLIS**

**BOOTH 83**

**MEDICAL RECORDS BY EDISON**

Last year we presented EDISON TELEVOICE!

Many Indiana hospitals have adopted this marvelous system and many of you are using it.

This year we proudly present the NEW EDISON—Very Portable Instrument—for recording medical records and correspondence in your office, your home, or in your car.

Available at low cost in Combination units—recording and transcribing on same instrument—or in separate recording and transcribing units.

See it at Booth 83.

**ENCYCLOPEDIA AMERICANA  
SUITE 433-434 PALMOLIVE BUILDING  
919 NORTH MICHIGAN AVENUE  
CHICAGO 11, ILLINOIS**

**BOOTH 65**

All members of the Indiana State Medical Association and their guests are cordially invited to visit our booth No. 65, where we will have the Mid-Century Printing of the Encyclopedia Americana, a supreme authority since 1829 and also the 40th Anniversary Edition of the world famous Book of Knowledge, finest of children's reference work—an American tradition.

**H. G. FISCHER & CO.  
9451-9491 W. BELMONT AVE.  
FRANKLIN PARK, ILL.**

**BOOTH 31**

At Booth 31 inspect H. G. Fischer & Co.'s modern, efficient, low priced x-ray and physical therapy equipment, including Short Wave diathermy machines having type approval of the Federal Communications Commission. Let their representatives point out many features of advantage in these units and other models not on display. Your visit welcome—No obligation.

**C. B. FLEET CO., INCORPORATED  
921-927 COMMERCE ST., LYNCHBURG, VA.**

**BOOTH 8**

C. B. Fleet Company, Inc., cordially invites you to stop at Booth 8 to see the exhibit of Phospho-Soda (Fleet). Phospho-Soda (Fleet) is a solution containing in each 100 cc. sodium biphosphate 48 gm. and sodium phosphate 18 gm.

Phospho-Soda (Fleet), over the years has won discriminating preference by thousands of physicians—because of its controlled action . . . its freedom from undesirable side effect—and its ease of administration. There is only ONE Phospho-Soda (Fleet).

**FREEMAN X-RAY COMPANY  
4528 W. LAWRENCE AVE., CHICAGO 30, ILL.**

**BOOTH 9**

**GENERAL ELECTRIC COMPANY  
X-RAY DEPARTMENT, MILWAUKEE 14, WIS.  
320 N. MERIDIAN ST., INDIANAPOLIS 4, IND.**

**BOOTH 57**

The General Electric Company, X-Ray Department with direct factory offices at 306 Chamber of Commerce Building, Indianapolis, Indiana, will exhibit the following equipment in their booth at the Indiana State Medical Meeting, October 28, 29 and 30, 1952:

- One Complete Radiographic and Fluoroscopic X-Ray Unit
- One New Type Direct Writing Electrocardiograph
- One New Type Short-Wave Diathermy

The following factory representatives will be in attendance:

- E. W. Horner, H. J. Wallace, J. H. Standard, R. C. Johnston, and W. E. Christensen.

**GERBER PRODUCTS COMPANY  
FREMONT, MICHIGAN**

**BOOTH 55**

The GERBER BABY greets physicians and their guests at the Indiana State Medical Association Meeting. Symbolizing the best in baby foods, he will continue pioneering research in the field of applied infant nutrition. His picture on "Starting" cereals, Strained and Junior foods and Gerber-Armour meats for babies is your assurance of uniform high quality.

**J. E. HANGER, INC.  
1407 N. ILLINOIS ST., INDIANAPOLIS 2, IND.**

**BOOTH 59**

J. E. Hanger, Incorporated, for ninety years designers and fabricators of prostheses for upper and lower extremity amputations, invites the members of the Indiana State Medical Association to attend their exhibit in Booth 59.

Our display will feature the latest developments in the prosthetic field including cosmetic restorations and the newly developed Army Prosthetic Research Laboratory mechanical hands and hooks as well as the improved suction socket limb for thigh amputation.

**HILL - ROM COMPANY, INC.  
BATESVILLE, INDIANA**

**BOOTH 47**

We invite you to inspect the wooden hospital furniture and equipment, including our new Recovery and Labor Bed in Booth No. 47.

**HOFFMANN - LA ROCHE INC.  
ROCHE PARK, NUTLEY 10, NEW JERSEY**

**BOOTH 38**

DROMORAN and GANTRISIN are featured at the Roche booth. DROMORAN is a new morphine analogue, the synthesis of which is listed among the ten most important advances in science and technology in 1951. GANTRISIN is the top-ranking sulfonamide because its higher solubility obviates renal blocking. Recent clinical data are available on these and other Roche products. Be sure to visit the Roche display.

**INDIANA VISUAL AIDS COMPANY, INC.  
726 N. ILLINOIS ST.  
INDIANAPOLIS 4, IND.**

**BOOTH 77**

Visual Aids will exhibit all types of visual equipment including cameras, projectors, tape recorders.

**KREMERS - URBAN CO.  
MILWAUKEE 1, WISCONSIN**

**BOOTH 30**

You are cordially invited to visit the Kremers-Urban booth. Our representatives will be delighted to answer any questions you may have concerning the line of K-U Council Accepted medications. We look forward again to meeting our many friends from Indiana.



**LANTEEN MEDICAL LABORATORIES, INC.**  
2020 GREENWOOD ST., EVANSTON, ILL.

**BOOTH 70**

**LEDERLE LABORATORIES DIVISION**  
**AMERICAN CYANAMID COMPANY**  
30 ROCKEFELLER PLAZA, NEW YORK 20, N. Y.

**BOOTH 109**

You are cordially invited to visit our exhibit in Booth 109 where you will find representatives who are prepared to give you the latest information on LEDERLE products.

**ELI LILLY AND COMPANY**  
INDIANAPOLIS 6, U. S. A.

**BOOTH 85**

Your Lilly medical service representative cordially invites you to visit the Lilly exhibit located in space 85. Featured will be a demonstration of functional packaging as an aid to medical practice. Modern manufacturing departments will be illustrated. Literature on new therapeutic developments will be available.

**LINCOLN LABORATORIES, INC.**  
LABORATORY PARK, BOX 1139, DECATUR, ILL.

**BOOTH 34**

Lincoln Laboratories will feature their Lyophilized Vitamin Products and Hormone Aqueous Suspensions. Lincoln Laboratories was a pioneer in both these fields, and the representatives in attendance will be happy to demonstrate the advantages of both to those visiting the Lincoln booth.

**J. B. LIPPINCOTT COMPANY**  
EAST WASHINGTON SQUARE  
PHILADELPHIA 5, PENNSYLVANIA

**BOOTH 56**

J. B. Lippincott Company presents, for your approval, a display of professional books and journals geared to the latest and most important trends in current medicine and surgery. These publications, written and edited by men active in clinical fields and teaching, are a continuation of more than 100 years of traditionally significant publishing.

**P. LORILLARD COMPANY, INC.**  
119 WEST 40TH STREET, NEW YORK 18, N. Y.

**BOOTHS 106 AND 107**

P. Lorillard Company, manufacturers of OLD GOLD and EMBASSY Cigarettes as well as BRIGGS Pipe Mixture and other famous tobacco products, will exhibit and demonstrate their new KENT Cigarette with the exclusive Miconite Filter which takes out seven times more nicotine and tars than any other leading filter cigarette.

**M & R LABORATORIES**  
COLUMBUS 16, OHIO

**BOOTH 78**

Your SIMILAC representatives are happy to take part in this meeting. They are pleased to have the opportunity to discuss with you the role of SIMILAC in infant feeding. They have for you the latest Pediatric Research Conference reports. Current reprints of Pediatric nutritional interest are also available.

**MAICO OF INDIANA**  
923 HUME MANSUR BUILDING  
INDIANAPOLIS 4, INDIANA

**BOOTH 12**

MAICO OF INDIANA,  
MAICO OF FORT WAYNE,  
MAICO OF SOUTH BEND,

distributors of medical acoustical instruments, welcome all physicians and allied professions to Booth No. 12. Maico supplies 90 percent of all hearing test instruments in the world, as well as being foremost in fine hearing aids. Competent and courteous representatives assist in surveys of industrial noise levels and hearing conservation testing programs.

**MEAD JOHNSON & COMPANY**  
EVANSVILLE 21, IND., U. S. A.

**BOOTH 2**

Pioneers in cooperating with the medical profession in the field of infant feeding, Mead Johnson & Company now has a comprehensive group of nutritional products. Of special interest are Dextri-Maltose, a specially prepared carbohydrate for infant feeding, Lactum, a canned evaporated formula made from whole milk and Dextri-Maltose, and the family of **four** Pabulum cereals with recently developed improvements in texture, flavor, quality and packaging.

**MEDCO PRODUCTS COMPANY**  
3607 E. ADMIRAL PLACE, TULSA 12, OKLA.

**BOOTH 87**

The Medcotron Stimulator, for the stimulation of innervated muscle or muscle groups ancillary to treatment by massage, is a low volt generator that will generate plenty of your interest. Electrical muscle stimulation is a valuable form of rehabilitation therapy. Be sure to visit Booth No. 87 for a personal demonstration.

**THE MEDICAL PROTECTIVE COMPANY**  
FORT WAYNE, INDIANA

**BOOTH 29**

Having completed another year in which not a single policyholder suffered involuntary loss from his own pocket in a malpractice claim or suit defended by this unique organization, despite large losses reported elsewhere, The Medical Protective Company, Specialists in Professional Protection Exclusively since 1899, invite your visit with its representatives at Booth 29. Answers to problems in the Doctor-Patient relationship are yours for the asking.

**THE WM. S. MERRELL COMPANY**  
CINCINNATI, OHIO

**BOOTH 51**

MERRELL will feature DIOTHANE Ointment, a topical anesthetic widely prescribed for positive and prolonged comfort in hemorrhoidal pain. Also in other areas that require prolonged contact where it is desirable to provide a protective antiseptic coating. Of low toxicity, DIOTHANE has established a reputation for "comfort in hemorrhoidal pain."

**MIDWESTERN HOSPITAL & SURGICAL  
SUPPLY CO.**

515 TYLER ST., GARY, IND.

**BOOTH 64**

The Midwestern Hospital and Surgical Supply Company of Gary has many products of outstanding interest to show you, Doctor, at booth number "64" right in the center of the exhibit hall.

RAYTHEON DIATHERMY—Radar waves are put through peace time application in the only completely new, simplest, and safe form of heat therapy available.

BIRTCHEER SUPER POWER EXAMINING LIGHT—The new portable operating room lamp adapted especially for the doctor's office.

PELTON AUTOCLAVE—Operates in the same manner as the large hospital autoclaves in that it kills all bacteria yet provides the speed necessary for the busy doctor's office.

There will be other interesting products on display at booth "64" including many new instruments and surgical appliances, and some of the modern advancements in the pharmaceutical industry.

**MILLER SURGICAL COMPANY**

2449 N. PULASKI ROAD, CHICAGO 39, ILL.

**BOOTH 71**

MILLER SURGICAL COMPANY, Chicago, Illinois (Booth 71), will exhibit Electrically Illuminated Gorsch and Miller Rectal Scope, Rectal Snares, Smoke Ejectors, Coagulators, Miller Electro-scalpel and Cautery, Headlites, Reflecting etc., Miller Ophthalmoscope, Oscopes and complete line of Illuminated and Magnifying Surgical Diagnostic Units.

**MUTUAL MEDICAL INSURANCE, INC.**  
(The Blue Shield Plan)

500 TERMINAL BUILDING, INDIANAPOLIS

**BOOTH 63**

Mutual Medical Insurance, Inc. (Blue Shield Plan) will have its exhibit in Booth No. 53.

Representatives of the Plan will be on hand at all times to answer questions and be helpful in any way possible. Special materials will be distributed explaining the operation of the Plan, the benefits it affords the physician and the public, and showing the growth of the Plan in membership during the past five years.

Dr. Walter U. Kennedy, New Castle, is president of the Blue Shield Plan; Dr. W. Harry Howard, Hammond, is vice-president; Dr. Walter L. Portteus, Franklin, is secretary; and Dr. A. F. Weyerbacher, Indianapolis, treasurer.

Administration of The Blue Shield Plan is under the direction of R. S. Saylor, Executive Vice-President, 500 Terminal Building, Indianapolis.

**ORTHO PHARMACEUTICAL CORPORATION**  
RARITAN, NEW JERSEY

**BOOTH 81**

ORTHO cordially invites you to visit their exhibit at Booth No. 84. ORTHO-GYNOL, ORTHO-CREME, and ORTHO DIAPHRAGMS will be featured.

**PARKE, DAVIS & COMPANY**  
DETROIT, MICHIGAN

**BOOTH 3**

Medical service members of our staff will be in attendance at our exhibit for consultation and discussion of various products of particular interest to members of the Association. Important specialties, such as Benadryl, Oxycel, Thrombin Topical, etc., will be featured.

**THE PELTON & CRANE COMPANY**  
632-652 HARPER AVENUE, DETROIT 2, MICHIGAN

**BOOTH 95**

**PET MILK COMPANY**  
ST. LOUIS 1, MISSOURI

**BOOTH 40**

Specially trained representatives will be in attendance to discuss the use of Pet Milk in infant feeding, and to present many services that are time-savers for busy physicians. Miniature Pet Milk cans will be given to visitors at the exhibit.

**CHAS. PFIZER & CO., INC.**  
630 FLUSHING AVE., BROOKLYN 6, N. Y.

**BOOTH 99**

Terramycin, newest of the broad-spectrum antibiotics, forms a dramatic central feature of the display of Chas. Pfizer & Co., Inc., Brooklyn, New York. The newest dosage forms of Terramycin are exhibited and indications for use are described.

**PHILIP MORRIS & COMPANY, LTD., INC.**  
100 PARK AVE., NEW YORK, NEW YORK

**BOOTH 74**

Philip Morris and Company will show the results of research on the irritant effects of cigarette smoke. These results show conclusively that Philip Morris are less irritating than other cigarettes. An interesting demonstration will be made on smokers at the exhibit which will show the difference in cigarettes.



**PITMAN-MOORE COMPANY**  
**Division of Allied Laboratories, Inc.**  
**INDIANAPOLIS 6, INDIANA**

**BOOTH 80**

Pitman-Moore's exhibit will feature several outstanding biological and pharmaceutical preparations which bear the seal of acceptance of the Council on Pharmacy and Chemistry of the A.M.A. Mr. Lester E. Davis, Central Regional Manager, who will be in charge of this display, extends an invitation to all members of the Indiana State Medical Association to visit the Pitman-Moore booth.

**REX TYPEWRITER EXCHANGE**  
**207 MASSACHUSETTS AVE., INDIANAPOLIS, IND.**

**BOOTH 73**

Be sure to visit the Rex Typewriter Exchange Booth. We will have on display all the latest models of Webster Chicago Wire Recorders and Tape Recorders. See the new Model 228 Dictation wire recorder, with push to talk microphone, two-way foot control with back spacer, and other new features. Also see the new Model 210 Tape Recorder that records up to two hours, and has fast forward and fast reverse speeds for your convenience. The new model 228 Wire Recorder will fit all your dictating and transcribing needs at a very low cost. Stop in and have your voice recorded and learn what a time-saver one of these machines can be in your office. Curt Benner will have charge of the display.

**RICKRICH SURGICAL SUPPLY COMPANY**  
**801-803 W. INDIANA ST., EVANSVILLE 10, IND.**

**BOOTH 10**

A cordial invitation is extended to all physicians to visit our display in Booth No. 10. Many new items will be shown.

George F. Carter, John Stephens and I. J. Rickrich will be there to greet you.

**A. H. ROBINS COMPANY, INC.**  
**RICHMOND, VIRGINIA**

**BOOTH 58**

The A. H. Robins Company exhibit features ROBAX-LATE, N.N.R., antacid-demulcent indicated in peptic ulcer therapy and hyperacidity. The pharmaceutically elegant tablets, each containing 0.5 Gm. dihydroxy aluminum aminoacetate, are notable for exceptional palatability and smooth, non-chalky texture.

**THE W. H. RODEBECK COMPANY**  
**15 E. MARYLAND ST., INDIANAPOLIS 4, IND.**

**BOOTH 20**

**Steno Dictating Unit 'Ideal' for Doctors**

Professional men of Indiana have shown much interest in the new Steno dictating-transcribing equipment. The Steno machine will be on display at the forthcoming Indiana State Medical Association Convention.

The Steno is ideal for physicians, because technical medical terms are transcribed clearly and the unit is easy to operate. The machine enables a doctor to make recordings from the patient's view. This feature is especially valuable in making subjective examinations, or recording case histories and clinical findings. Most outstanding of Steno features is the fact that only one basic unit is needed. The dictation unit is transformed into a transcriber by merely pushing a button. A doctor's day is rushed. He cannot take time to fuss with mechanical gadgets. Steno is ready to do whatever you ask it to do by simply pushing a button. Every action is automatically controlled.

The W. H. Rodebeck Company, 15 East Maryland Street, Indianapolis, Indiana, is the State distributor for Steno equipment.

**RYSTAN COMPANY, INC.**  
**7 N. MacQUESTEN PKWY., MOUNT VERNON, N. Y.**

**BOOTH 61**

Rystan Company, Inc., pioneers in chlorophyll therapy, will exhibit Chloresium Ointment and Chloresium Solution (Plain), therapeutic chlorophyll preparations for the topical treatment of wounds, ulcers, burns and dermatoses. These Council-Accepted Chloresium products promote the growth of healthy granulation tissue, provide relief from itching and local irritation, and deodorize malodorous lesions. Representatives will be pleased to discuss specific applications of these products and recent clinical reports.

**SANDOZ PHARMACEUTICALS**  
**DIVISION OF SANDOZ CHEMICAL WORKS, INC.**  
**68-72 CHARLTON STREET, NEW YORK 14, N. Y.**

**BOOTH 37**

It is with a great deal of pleasure and pride that we invite you to visit our scientific exhibit at the forthcoming convention, October 28 to 30, 1952.

Our booth number is 37.

Our Indiana representative, Mr. Robert N. Pitts, will gladly welcome you.

**W. B. SAUNDERS COMPANY**  
**WEST WASHINGTON SQUARE**  
**PHILADELPHIA 5, PENNSYLVANIA**

**BOOTH 79**

Available for your inspection at the Saunders Booth will be such new and attractive books as: Beckman's Pharmacology in Clinical Practice; Shaffer & Chapman's Correlative Cardiology; Lewis' Practical Dermatology; Bland's Clinical Use of Fluid and Electrolyte; Surgical Practice of the Lahey Clinic; Cecil's Specialties in General Practice; and Meschan's Normal Radiographic Anatomy.

Also such standard works as: Cecil & Loeb's Medicine; the Dorland Dictionary; Mitchell-Nelson's Pediatrics; Greenhill-DeLee's Obstetrics; Graybiel & White's Electrocardiography; Novak's Gynecologic and Obstetric Pathology; and more than 100 others.

**SCHERING CORPORATION****2 BROAD STREET, BLOOMFIELD NEW JERSEY****BOOTH 76**

Members of the Indiana State Medical Association and their guests are cordially invited to visit the Schering Exhibit where new therapeutic developments will be featured.

Schering representatives will be present to welcome you and to discuss with you the products of our manufacture.

**SEALY MATTRESS COMPANY****903-933 N. HALSTED ST., CHICAGO 22, ILL.****BOOTH 13**

The Sealy Mattress Company will proudly present and display at the Indiana State Medical Convention the Sealy Posturepedic Firm-O-Rest mattress and matching foundation.

This fine orthopedic type bedding equipment has been featured at every national American Medical Association Convention for the past four years.

This world's largest selling orthopedic type mattress is now nightly being slept upon by over 10,000 doctors.

The Posturepedic mattress and foundation will be displayed and physically demonstrated by factory trained technicians.

Sealy continues to offer the special professional discount for their own personal use, to all interested doctors in attendance at the convention.

**G. D. SEARLE & CO.  
CHICAGO, ILL.****BOOTH 1**

You are cordially invited to visit the Searle booth where our representatives will be happy to furnish you with information regarding Banthine, the true anticholinergic drug for the treatment of peptic ulcer and other parasymphathotonic conditions; Dramamine, for motion sickness; Metamucil, for the physiological treatment of constipation; and Alidase for hypodermoclysis at intravenous speed.

**SEVEN-UP BOTTLING COMPANY  
INDIANAPOLIS****BOOTH 11****SHARP & DOHME  
PHILADELPHIA 1, PENNSYLVANIA****BOOTH 75**

Research data relative to the potentiating effect of the antibiotics, Bacitracin and Tyrothricin, are featured in the Sharp & Dohme booth. The synergistic effect of penicillin in conjunction with the sulfonamides and clinical data on the use of vitamin B12 are also of major interest. Our representatives will welcome your visit.

**SMITH, KLINE & FRENCH LABORATORIES****1530 SPRING GARDEN STREET****PHILADELPHIA 1, PENNSYLVANIA****BOOTH 50**

We extend a cordial invitation to you to visit our booth where we will feature one of the fundamental drugs in medicine, 'Benzedrine' Sulfate N.N.R. (racemic amphetamine sulfate, S.K.F.) Our representatives will be happy to discuss this valuable central nervous stimulant and anorexigenic agent which is so highly effective in controlling appetite in the treatment of obesity.

**SPENCER SUPPORTS—MADGE L. ROBBINS****622 HUME MANSUR BLDG., INDIANAPOLIS 4, IND.****BOOTH 32**

You are invited to see the display of Spencer Supports—individually designed for each patient to improve body mechanics and thus aid treatment.

Of special interest are Spencer designs of proven clinical effectiveness in treatment of angina pectoris, postural hypotension and chronic arthritis.

Various posture-improvement and orthopedic supports are on display.

Ask for information on Spencer Breast Supports designed for each individual need including antepartum, postpartum, ptosis, hypertrophy and mastectomy.

**E. R. SQUIBB & SONS****SQUIBB BUILDING, 745 FIFTH AVENUE****NEW YORK 22, NEW YORK****BOOTH 25**

New Squibb products, and new brochures of useful interest to you on products already introduced, will be featured at Booth No. 25.

As in former years, your Squibb representative again cordially invites you to visit the Squibb booth.

**U. S. STANDARD PRODUCTS CO.****WOODWORTH, WISCONSIN****BOOTH 88**

Our representatives, Milt Reisman, Bill Snider, Glenn Crane and A. E. Zornig, will be in attendance at Booth 88.

**U. S. VITAMIN CORPORATION****250 EAST 43RD STREET, NEW YORK 17, N. Y.****BOOTH 52**

Exhibit demonstrates the new "oil-in-water" Aquasol Vitamin A Drops . . . providing natural vitamin A in aqueous solution.

Also taste for yourself the new and different sodium-free salt substitute—Co-Salt—which actually tastes like salt, looks like salt and sprinkles like salt . . . a great boon to your patients on restricted sodium intake.

**THE UPJOHN COMPANY****KALAMAZOO, MICHIGAN****BOOTH 82**

The Upjohn display will feature Cortisone. Our new method for producing Cortisone enables a larger number of patients to receive Cortisone therapy due to reduction in cost. Our representative will be pleased to discuss Cortisone and other Upjohn products with visiting physicians.



**VARICK PHARMACAL CO., INC.****72 VARICK ST., NEW YORK 13, NEW YORK****BOOTH 68**

Varick Pharmacal Co., Inc.—E. Fougera & Co., Inc., cordially invite physicians to discuss with Professional Service Representatives new preparations of importance to their every day practice. Descriptive literature and samples of all products will be available.

**THE WARREN-TEED PRODUCTS COMPANY****582 W. GOODALE ST., COLUMBUS 8, OHIO****BOOTH 69**

The Warren-Teed Products Company cordially invites you to visit their exhibit at Booth No. 69. Sinan—(brand of Mephenesin Warren-Teed) used in the treatment of certain spastic and neuromuscular disorders will be featured at this exhibit. The pharmacological action of Sinan will be dramatically demonstrated through the medium of fluorescent paints activated by alternating white and ultra-violet light. Courteous representatives will be in attendance to assist registrants in any way possible.

**WHITE-HAINES OPTICAL COMPANY****P. O. BOX 1878, COLUMBUS, OHIO, AND HUME MANSUR BUILDING, INDIANAPOLIS****BOOTH 86****WHITE LABORATORIES, INC.****KENILWORTH, NEW JERSEY****BOOTH 41**

GITALIGIN—which has been described as a "... digitalis preparation of choice"—will be on display at Booth No. 41. White's Representatives will appreciate the opportunity to discuss with you the clinical background and therapeutic merit of this and other outstanding White's products.

**WINTHROP-STEARN'S INC.****1450 BROADWAY, NEW YORK 18, NEW YORK****BOOTH 42**

WINTHROP-STEARN'S INC., New York, extends a cordial invitation to visit Booth No. 42, where representatives will be on hand to discuss the latest therapeutic contributions made by this firm. Featured will be:

ISUPREL, efficient and convenient bronchodilator. Tablets for sublingual use, solution for inhalation.

MILIBIS, new, virtually non-toxic amebicide.

TELEPAQUE, the new, highly effective and well tolerated oral cholecystopaque medium. Gives denser, clear cut pictures of the gallbladder and, in a substantial number of cases, also permits visualization of the biliary ducts.

NEOCURTASAL IODIZED, trustworthy salt without sodium, with the addition of 0.01 percent potassium iodide.

**WYETH INCORPORATED****1401 WALNUT ST., PHILADELPHIA 2, PA.****BOOTHS 44 AND 45**

You are cordially invited to visit the display of Wyeth Incorporated. This will feature:

WYDASER—highly purified hyaluronidase with a wide range of clinical applications.

THIOMERINR—recently developed, effective mercurial diuretic particularly adaptable to self administration.

S-M-AR—modern infants' formula, unsurpassed in similarity to human milk.

PURODIDINR—crystalline digitoxin, for precise control of digitalis action by oral administration.

Representatives will be on hand to discuss and supply literature concerning these and other widely prescribed Wyeth ethical specialties.

**ZIMMER MANUFACTURING COMPANY****WARSAW, INDIANA****BOOTH 7**

Zimmer will exhibit the Brown Electro Dermatome, Splints for use by the General Practitioner, and Orthopedic Appliances including Femoral Prostheses.



## News Notes

### Wells County Conference Set

The sixth annual **Fall Clinical Conference** of the **Wells County Medical Society** will be featured by talks by Dr. George Andros, Chicago Lying-In Hospital; Dr. Howard P. Doub, chief radiologist, Henry Ford Hospital, Detroit; Dr. Robert E. L. Berry, associate professor of surgery, University of Michigan School of Medicine, Ann Arbor; Dr. Jerome Conn, professor of internal medicine, also of Ann Arbor; Dr. Matthew Winters, professor of pediatrics and Dr. Leslie W. Freeman, department of surgery, both of the Indiana University School of Medicine, Indianapolis.

Dr. J. William Wright, president of the Indiana State Medical Association will be a special guest at the conference which is scheduled for October 8 in the Parlor City Country club, north of Bluffton.

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Four Indiana doctors have been named to the board of governors of the Central States Society of Industrial Medicine and Surgery. **Dr. Virgil McCarty**, Princeton, will serve during 1953; **Dr. Eli S. Jones**, Hammond, and **Dr. Emmett B. Lamb**, Indianapolis, through 1954, and **Dr. H. Glenn Gardiner**, East Chicago, through 1955.

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Members of the Wisconsin Medical Association will hear two Indianapolis doctors at their Annual meeting in Milwaukee October 6-8. **Jacob K. Berman**, M.D., assistant professor of surgery at Indiana University School of Medicine and **Sprague H. Gardiner**, M.D., assistant professor of obstetrics and gynecology at the I. U. School of Medicine will each conduct a round table luncheon discussion and appear as featured speakers on the program. C. Walter McCarty, editor of the Indianapolis News, will be the speaker at the annual dinner. He will talk on "Journalistic Obstetrics."

### A Surgical Urinal



(Designed by C. O. McCormick)

Having long since been impressed by the impracticability of the circular and kidney-shaped basins customarily used in most all surgeries for the collection of urine during abdominal cesareans and those pelvic operations where an empty bladder is to be maintained, I designed the utensil herewith illustrated. As observed, it is employed in conjunction with an anchored catheter.

This vessel is cast of aluminum and has the ample capacity of 10 ounces. It is durably made and is easily cleansed and sterilized. The lateral surfaces are so designed as to fit comfortably between the patient's thighs. This feature combined with extra depth eliminates the spilling so frequently experienced with the usual basins. Its narrow width permits the added advantage of close approximation of the patient's limbs.

This urinal is satisfactorily used in the various Indianapolis hospitals.

C. O. McCORMICK, SR.,  
Indianapolis, Indiana



### Medical Library Group to Meet in Indianapolis

The fall meeting of the **Midwest Regional Group of the Medical Library Association** will be held in the Lilly Research Laboratories in Indianapolis on October 17 and 18. The first meeting is scheduled for 3:15 p.m., according to Marguerite Gima, Hammond, chairman.

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**Dr. John A. Shively**, a graduate of the Indiana University School of Medicine, and **Dr. Robert Huber**, a graduate of the University of Minnesota, have joined the staff of the Caylor-Nickel Clinic at Bluffton. Dr. Shively will serve as clinical pathologist and laboratory director and Dr. Huber will serve a two-year residency in radiology.

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**Dr. Francis W. Hare**, who has been associated with the Lahey Clinic, Boston, has joined **Drs. Lewis E. Jolly, Robert O. Zink, Marcella S. Modisett** and **Jackson W. Modisett** in practice at Madison. He will specialize in internal medicine.

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The **American Urological Association** offers an annual award for the three best essays on the result of some clinical or laboratory research in urology with competition limited to urologists who have been in such practice not more than five years and to men in training to become urologists. First prize is \$500, second \$300 and third \$200. Essays must be in by January 15, 1953. Details may be obtained from William P. Didusch, 1120 North Charles Street, Baltimore, Maryland.

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**Dr. Herbert J. Karol**, who was on the Indianapolis General Hospital staff for three years, has opened an office in Fort Wayne where he will practice urological surgery. He is a native of Chicago, graduate of the University of Illinois College of Medicine and interned at Cook County hospital. Dr. Karol spent three years in the Pacific theatre during World War II.

**Dr. Albert C. Yoder**, Goshen, who last December was named "Family Doctor of the Year" at the American Medical Association's convention in Los Angeles, is recovering slowly from injuries received in a head-on automobile collision in Goshen. Dr. Yoder is now at Goshen Hospital, having been brought there recently from Memorial Hospital, South Bend. He suffered a fractured knee cap and will use a walker for some time.

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**Stephen R. Phelps, M. D.**, assumed the practice of the late Louis A. Sandoz in South Bend September 15. Dr. Phelps will specialize in dermatology and syphilology. He is a graduate of the University of Kansas School of Medicine and interned at Swedish Hospital, Seattle. Dr. Phelps has just completed his residency at Indianapolis General Hospital.

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**Dr. C. F. Stallman**, who has just completed his internship at Ball Memorial Hospital, Muncie, has opened an office for the practice of medicine and surgery in Kendallville. After serving four and one-half years overseas during World War II, Dr. Stallman completed his studies and was graduated from Indiana University School of Medicine in 1951.

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**Capt. John A. Peterson**, a native of Whiting and graduate of Indiana University School of Medicine, 1949, has been assigned to the Office of the Air Force Surgeon General as assistant chief, Biologic Defense branch, Preventive Medicine division.

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The Hotel Statler, New York, will be the site of the Seventeenth Annual Convention and Scientific Sessions of the **National Gastroenterological Association** on October 20-22. The association will conduct its fourth annual course in Postgraduate Gastroenterology in the Statler on October 23-25. Further information on both sessions may be obtained from the Secretary, National Gastroenterological Association, 1819 Broadway, New York 23, N. Y.

**Dr. John H. Warvel**, Indianapolis, has been appointed to a three year term on the Council of the American Diabetes Association and named a member of the association's committee on detection and education. Dr. Warvel is a pioneer in the fight to conquer diabetes.

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A prize of \$300 is being offered by the **American Dermatological Association** for the best original essay, not previously published, relative to some fundamental aspect of dermatology or syphilology. Manuscripts should be typed in English, double spaced with ample margins, should be accompanied by illustrations, charts and tables and should be submitted in triplicate not later than January 1, 1953 to Dr. Louis A. Brunsting, Secretary, American Dermatological Association, 102-110 Second Ave., S. W., Rochester, Minnesota.

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Among the new officers of the Chicago Society of Allergy is **Dr. Simon S. Rubin**, Gary, who will serve as secretary-treasurer.

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Members of the Hagerstown Rotary club have elected **Dr. William A. Miller** to honorary membership, a rare distinction. The honor was in recognition of Dr. Miller's "outstanding service to the community."

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**Dr. Edward Apple**, 1951 graduate of the Indiana University School of Medicine, recently began the general practice of medicine in Salem. He served his internship at General Hospital, Indianapolis.

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**Dr. Mary L. Gorton** has resigned as psychiatrist-medical director of the Lake County Mental Hygiene Clinic which is sponsored by the Lake County Medical Society. Dr. Gorton has practiced in Hammond since 1946. She will go to California to direct three mental clinics.

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Offices have been opened in Worthington by **Dr. Paul Pickett, Jr.**, physician and surgeon. Dr. Pickett, a World War II veteran, was graduated from Indiana University School of Medicine in 1951 and served his internship in Hermann Hospital, Houston, Texas.

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## Doctors Urged to Send in Poisoning Reports

The Committee on Pesticides of the American Medical Association currently is undertaking a country-wide toxicological study of cases of poisoning resulting from the use of insecticides, rodenticides, fungicides, weed killers, fumigants, repellents and related types of chemicals used in agriculture and the home. This information will be used to expand its permanent file of such cases for use by physicians and allied medical personnel.

Since much of the committee's information on pesticide poisoning has been compiled from unpublished isolated cases which were brought to its attention, the committee appeals to physicians to submit records on cases of non-fatal and fatal poisonings from pesticides. The committee points out that summary data on the pertinent facts of the poisonings and the circumstances of their occurrence would be sufficient in most instances. The committee is functioning as a center for reporting this type of poisoning cases.

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**Dr. William A. Johnson**, formerly of Harrisville, Michigan, has moved to Mount Vernon where he will enter the general practice of medicine. A graduate of Miami University, Dr. Johnson received his degree from the University of Michigan. He served two years in the navy.

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Fairmount's new physician, **Dr. M. Arthur Grant**, has established his general practice offices in the location formerly occupied by the late Dr. L. D. Holliday.

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**Dr. Carl J. Elward**, a graduate of Loyola University's Stritch School of Medicine, has joined his brother-in-law, **Dr. William E. Pearson**, in the practice of medicine in Wabash. Dr. Elward spent three years in the army medical corps in the European theatre. He interned at Cook County and Mercy hospitals, Chicago.

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**Don G. Bock, M.D.**, Indianapolis, is now stationed at Walter Reed Army Medical Center, Washington, D. C. Captain Bock will reside in Silver Spring, Maryland.



## A.M.A. WASHINGTON OFFICE NEWS

**Brookings Cites U. S. Health Gains**

Medical and health gains in the past 50 years are cited in the 352-page volume titled *Health Resources of the United States* which Brookings Institution has published. The book is described by the institution as "the factual foundation for future Brookings publications in the field which will offer analyses of a number of scientific and social problems relating to health." The volume is the work of George W. Bachman and associates, who spent three years in research. The institution said more than 700 private and public agencies contributed material for analysis.

The book is divided into three parts. Part I reviews the state of the nation's health during the first half of this century. Part II deals with health personnel, including medicine, dentistry, nursing and auxiliary personnel, and also medical group practice. Part III is devoted to hospitals and related facilities, specified diseases and disabilities, environmental health, federal health services and health service in industry. Copies are available at Brookings Institution, 722 Jackson Place N.W., Washington 6, D. C. at \$5 a copy.

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**Army and Air Force Request 371  
Physicians, 200 Dentists**

Army and Air Force have asked Selective Service to draft 371 physicians and 200 dentists in October. The Army quota is 196 physicians, 110 dentists; the Air Force, 175 physicians, 90 dentists. Defense Department said the October calls will bring the total inducted or called to active duty since July, 1951 to 1,893 physicians and 850 dentists. Selective Service already has begun classification of Priority 3 physicians registered under Doctor-Draft, but Armed Forces Medical Policy Council says no callups are due in this category before next April or May.

**Proposes Turning Federal Hospitals  
Over to Communities**

A panel group of the *President's Commission on the Health Needs of the Nation* proposes that hospitalization for federal beneficiaries be provided locally. The panel on *medical care of veterans* and other federal beneficiaries suggests that existing federal hospitals be turned over to communities "for nominal fees" with the federal government paying the costs of hospitalizing its cases. The panel would place responsibility for staffing and operating hospitals with the communities. Such a procedure, the panel stated, "would eliminate competition between federal and local hospitals for scarce medical personnel, would make medical care equally available to all federal beneficiaries and would eliminate the problem of administering a large and bulky service." The commission has taken no action on the proposal, which was presented during a two-day open session. The commission makes its final recommendations to the President in December.

The proposal was opposed by Vice Admiral Joel T. Boone, chief medical director of Veterans Administration. He said it would result in a "super-colossal" hospital operation and "spotty treatment" for veterans.

Dr. James C. Sargent, chairman of the AMA Council on National Emergency Medical Service, appearing on one of the panels, stated the AMA was opposed to unwarranted extension of medical care to dependents of service personnel. Dr. Sargent also noted the AMA was concerned over proper utilization of physicians in the armed services. The commission was informed by Dr. Anthony J. J. Rourke, president, American Hospital Association, that because of increased volume of private patients under prepayment health plans, there has been a marked drop in the number of ward patients for the teaching services. He said if this trend continues, "... some other way will have to be found for training the doctors of tomorrow."

## *Indiana University News Notes*

Three major construction projects are under way on the Indiana University Medical Center campus, representing further expansion of facilities in the educational, research and hospital service fields.

Scheduled for completion early next year is the Union-Food Service building which will fill the growing need for residence quarters, for added kitchen and food service space, for meetings of postgraduate and other groups, and for recreational facilities for both students and staff.

During the summer contracts were awarded and work is well advanced on the erection of a cancer research wing in which will be grouped investigative studies of malignancy, and a shops and stores building which will permit transfer of carpenter, plumbing and other maintenance headquarters from basement quarters under Riley and Rotary. The Cancer unit, a duplicate in size and design of the Riley Research Wing, will contain a small clinical metabolic unit for cancer patients and complete laboratory facilities.

Fall semester of the School of Medicine got under way with registration for the Sophomore and Junior class members at the Medical School on the Indianapolis campus, Monday, September 22. A convocation was held September 23 and formal classes opened on September 24. Senior students registered September 15, starting clerkships and didactic work. The 150 members of the first-year class in medicine report to the Bloomington campus.

A grant of \$56,500 has been received by the School of Medicine from the Rockefeller Foundation, covering a three-year research program in psychotherapy. The study, directed by Dr. Herbert S. Gaskill and Dr. Philip F. D. Seitz of the Department of Psychiatry, will be concerned with the effectiveness of different methods of treating emotionally ill persons.

With more than 100 polio patients at the Robert W. Long and James Whitcomb Riley hospitals for the past several weeks, Medical Center officials have faced a major problem in securing nurses. Appeals have been made to hospitals not faced with polio-care problems, to release nurses for polio duty at the Medical Center and other hospitals where these patients are accepted.

Bulk of the income from an \$190,800 estate left by the late William M. Bartlett, one-time prominent Indianapolis businessman, will be available for research studies at the Medical Center, according to the Riley Memorial Association.

Drs. H. R. Hulpieu, Robert Forney and William Clark of the Medical School staff attended sessions of the pharmacology division of the American Societies for Experimental Biology. Papers were presented by Dr. Hulpieu and Dr. Forney.

Remodeling and expansion of the School of Medicine library has been completed and a number of facilities have been added.

Dr. Edwin N. Kime attended the recent meeting of the International College of Surgeons in Chicago.

Sixty-six young women are enrolled in the freshman class of the Training School for Nurses and began their studies August 25. This is the largest beginning class in recent years.





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**NOW ARE:**

*SYMPTOMATIC CONTROL OF  
NAUSEA AND VOMITING  
ASSOCIATED WITH*

*pregnancy  
therapy with certain drugs (antibiotics, etc.)  
electroshock therapy  
narcotization*

*MANAGEMENT OF VERTIGO IN*

*Ménière's syndrome  
radiation sickness  
hypertension  
fenestration procedures  
labyrinthitis*

*MANAGEMENT OF  
VESTIBULAR DYSFUNCTION  
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*Streptomycin therapy*

Tablets: 50 mg. each  
Liquid: 12.5 mg. in each 4 cc.

*—and, of course, MOTION SICKNESS*

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## Deaths

**Frank A. Gutierrez, M.D.**, 55, Gary physician since 1926, died suddenly of a heart attack on August 22. A native of Puerto Rico, Dr. Gutiérrez attended George Washington University in Washington, D. C. and received his medical degree from Loyola University. He practiced first in Indiana Harbor, going to Gary in 1926. He was a former Gary health commissioner and was named first chairman of the Lake County Health Board when it was organized in 1949.

**Ermil T. Leslie, M.D.**, Evansville, died on August 27 as the result of injuries suffered in a fall at his home. Born in 1904, Dr. Leslie was a 1934 graduate of the Indiana University School of Medicine. A specialist in surgery, he was in private practice. Dr. Leslie was a member of the Indiana State Medical Association and the American Medical Association.

**C. M. Gillespie, M.D.**, 68, died July 29 in South Bend after being critically ill for a week. Dr. Gillespie had been practicing in Rome City for three months, going there from Medaryville. He was a member of the Indiana State Medical Association.

**Lawrence B Rariden, M.D.**, 66, Greenfield, died August 26 following an illness of several years' duration. Born in 1886 in Mitchell, Dr. Rariden was graduated from the Indiana University School of Medicine in 1912. He started practice in Brookston, served in the U. S. Medical Corps during World War I, then returned to Greenfield in 1920 where he had practiced since. He was the first president of the medical staff of the new Hancock County Memorial hospital and was a member of the Hancock County Medical Society and Indiana State Medical Association.

**Dr. Thomas E. Conner**, 79, Freetown, a practicing physician in Jackson county for 47 years, died August 7, in Louisville after a two months' illness. Born in Jackson county, Dr. Conner was graduated from the Medical College of Indiana, Indianapolis, in 1905. He had served as county health officer and county clerk of Jackson county. Dr. Conner was a senior member of the Indiana State Medical Association and a member of the American Medical Association.

**Oliver P. Bigelow, M.D.**, 67, Roanoke, died July 30 after an illness of 11 years. He had practiced in Roanoke for 24 years. Born in Kansas in 1884, Dr. Bigelow was graduated in 1908 from Western Reserve University School of Medicine, Cleveland. He practiced in Cleveland for 14 years. Dr. Bigelow was a member of Huntington County Medical Society and the Indiana State Medical Association.

**Roy H. Elliott, M.D.**, 76, for many years a practicing physician in Connersville, died on August 15 in Indianapolis where he had lived for the last two years since his retirement. Born in 1875, Dr. Elliott received his medical degree from the Miami Medical College, Cincinnati, in 1901. He served from 1918 until 1950 as secretary of the board of Fayette Memorial Hospital, was Fayette county health officer for 40 years, and was secretary of the Fayette-Franklin County Medical Society for many years serving for the first time in 1911. He was honored with a 50-year award from the Indiana State Medical Association several years ago. Dr. Elliott was also a member of the American Medical Association.

**Roy E. Shanks, M.D.**, Rushville, died on August 19. He was 55 years old. A graduate of the Indiana University School of Medicine, Dr. Shanks had practiced in Rushville since 1929. He was a member of the Indiana and the American Medical Associations.





## Salvino D'Armato's Glasses...

the first in Western Europe, ploughed him to his death. His tomb bears the inscription: "Salvino D'Armato, inventor of spectacles. God pardon him his sins. A.D. 1317."

Today it is a sin not to wear spectacles if you need them.

For patient satisfaction, prescribe Blue Ribbon optical wear, for the "only pair of eyes they'll ever have."

THE *White-Haines* OPTICAL COMPANY  
TERRE HAUTE, INDIANAPOLIS  
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## Shoes and Arches

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## Migraine In Children

"Migraine may appear during the first years of life. The presence of subjective signs, such as headache and flimmer scotoma, is often difficult to determine in young children. The true nature of the symptoms frequently remains obscure for years."

Vahlquist, B. and Hackzell, G.: Acta Paediatrica 38: 622 (1949).

NO. OF CASES	SEX	AGE AT ONSET	CYCLIC VOMITING	DURATION OF ATTACK	INTENSITY
31	8 ♀ 23 ♂	3 yrs. (mean)	3 out of 31	2½ hrs.	severe in all cases

TABLE CONT'D

NO. OF CASES	UNI- LATERAL HEADACHE	NAUSEA	FLIMMER SCOTOMA	VERTIGO	HEREDITY
31	18 out of 31	31 out of 31	12 out of 31	6 out of 31	20 out of 31

(reference given above)

In a study of 400 adult migraine patients, it was revealed that 34% had suffered attacks before the age of 15.\* These investigators concluded that childhood migraine was a much greater clinical problem than was previously believed and that psychodynamic mechanisms played an important part in the disease.

These criteria are useful in diagnosis:

Headache attacks with symptom-free intervals plus (at least two of the following) nausea, scintillating scotoma, hemicrania, and hereditary predisposition.

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For children within the age range 7 to 12 years—*Cafergot*® is administered, one tablet when the attack appears imminent followed by one additional tablet within 30 minutes. Not more than two *Cafergot* tablets should be administered to children within this age range.

In the adolescent age group, 12 to 18 years of age, the dosage may gradually be increased as necessary up to the usual adult dose, i.e., two tablets when the attack appears imminent followed by one tablet doses at half hour intervals until the attack is aborted. (Total maximum dose for adults: six tablets for each attack.)

\* Katz, J., Friedman, A.P., and Gisolfi, A.: New York State J. Med. 50: 2269 (Oct.) 1950.

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# Society Reports

## INDIANA STATE MEDICAL ASSOCIATION EXECUTIVE COMMITTEE

August 24, 1952

Roll call showed the following present: J. William Wright, M.D.; Paul D. Crimm, M.D.; Wemple Dodds, M.D.

Frank B. Ramsey, M.D., editor of *THE JOURNAL*; Albert Stump, attorney; James A. Waggener, executive secretary, and Robert J. Amick, field secretary.

### Membership Report

Number of members, August 23, 1952 ..... 3,664\*  
Number of members, August 23, 1951 ..... 3,591  
Gain over last year ..... 73

\*Includes 76 in military service (gratis)

108—\$10.00 members (residents and interns)

246—senior members

1—honorary member

62—members,

dues remitted by Council

### 1952 Annual Session, Indianapolis,

October 28, 29 and 30, 1952:

By consent, the committee approved the report on technical exhibits and the scientific program.

*Reserved tables at banquet for past presidents and councilors and their wives and wives of those seated at the speakers' table.* Dr. Wright is to ask Dr. McCaskey to again serve as chairman for seating the past presidents, councilors, their wives and the wives of those at the speakers' table.

By consent it was agreed that those guests who are members of the association should not be given complimentary tickets. In the letter of invitation to these members, it is to be stated that these members will be seated at the speakers' table and that tickets may be procured at the registration desk.

### Organization Matters

Copy of the report of the survey made by Purdue University was distributed to the members of the committee.

*A.M.A. interim session, Denver, December 2-5, 1952.* The executive secretary was instructed to procure a suite in Denver for the A.M.A. meeting, for use as a headquarters room, on motion of Drs. Dodds and Crimm.

### The Journal

*Report on advertising was accepted by consent:*

Total, August, 1951 ..... \$1,970.72

Total, August, 1952 ..... \$2,037.25

There being no further business, the committee adjourned to meet again at 10:00 a.m., Sunday, October 5, 1952, at the Columbia Club, Indianapolis.

## LOCAL SOCIETY REPORTS

Twenty-four members were present for the monthly meeting of the **Bartholomew-Brown County Medical Society** on September 10. Dr. Don White, Indianapolis, spoke on "Allergy". The meeting was held in the Harrison Lake Country club.

Dr. James A. Dickson, chief of orthopedic surgery at the Cleveland Clinic, Cleveland, spoke on "Hip Fractures" at the September 9 meeting of the **Vanderburgh County Medical Society**. More than 100 attended the meeting which was held in the Rose room of the Hotel McCurdy at 6:30. The next meeting of the society will be held at 6:30 o'clock, Tuesday evening, October 14, in Boehne hospital.

Seven members and one guest of the **Whitley County Medical Society** met in the Whitley County Memorial Hospital at Columbia City on August 12 where they viewed a film on "Anemia."

## INDIANA STATE BOARD OF HEALTH

### Division of Communicable Disease Control

#### MONTHLY REPORT—JULY 1952

Disease	July 1952	June 1952	May 1952	July 1951	July 1950
Chickenpox	35	143	356	33	33
Dysentery, bacillary	2	0	0	0	0
Encephalitis	4	6	5	2	1
Food infection	2	2	1	4	2
Influenza	2	3	9	21	0
Infectious hepatitis	11	34	21	4	0
Malaria (military)	3	6	9	0	0
Measles	303	538	2000	132	282
Meningitis,					
Unclassified	12	6	3	3	1
Meningococcal	4	4	12	1	1
Virus	1	0	0	0	0
Mumps	45	158	529	49	16
Pneumonia	32	34	64	26	25
Polio myelitis	63	19	5	25	23
Rabies in animals	17	20	14	35	60
Rubella	6	58	218	3	1
Streptococcal infections	67	46	176	26	21
Tetanus	2	2	1	1	0
Typhoid fever	3	3	2	5	1
Vincent's angina	1	0	0	1	3
Whooping cough	34	30	29	54	131





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## Books

### BOOK REVIEWS

**SPATIAL VECTORCARDIOGRAPHY.** By Arthur Grishman, M.D., Adjunct Physician for Cardiology, The Mount Sinai Hospital, New York; also connected with Beth Israel Hospital, New York; and Leonard Scherlis, M.D., Research Assistant in Cardiology, Mount Sinai Hospital. 217 pages with illustrations. Price \$6.00. The W. B. Saunders Company, W. Washington Square, Philadelphia 5, Pa. 1952.

This monograph is an elaborate presentation of the authors' work in this highly specialized field in which the placement of the electrodes is such as to define a cube rather than the more commonly studied equilateral tetrahedron. In justification of their choice they say, "In the cube arrangement each electrode is sufficiently distant from the dipole center for the exploration of its field. Furthermore, the tissue interposed between this center and the four electrodes is predominantly lung tissue. Therefore, the coefficients for all four electrodes are probably as nearly equal as can be achieved under biologic experimental conditions."

While for those now practicing electrocardiography the spatial vector method seems cumbersome these authors say, "There are distinct advantages to be gained in preceding instructions in routine electrocardiography by thorough instruction in spatial vectorcardiography. Spatial vectorcardiography has been found to provide a rational and scientific basis for instruction in electrocardiography."

This reviewer finds it difficult to accept the practical use of this method in routine work but agrees thoroughly with the authors' statement that, "The knowledge secured from an appreciation of the principles of spatial vectorcardiography can be applied with advantage in the routine reading of scalar electrocardiograms," and would not argue with their statement in another place, "Spatial vectorcardiography thus furnishes information over and above that which can be obtained from routine scalar electrocardiography whether interpreted in the usual manner or by vector principles."

The value of this book for the average practitioner in this field would seem to be the stimulation of critical thinking and the re-evaluation of one's knowledge of the methods he is now using.

The major portion of the book is devoted to a correlation of the records derived by this method and the standard scalar electrocardiograms and as such, at the present time, would seem of major interest to those in investigative work only.

S. L. J.

Books received are acknowledged in this column, and such acknowledgment must be regarded as a sufficient return for the courtesy of the sender. Selections will be made for more extensive review in the interests of our readers and as space permits. Books listed in this department are not available for lending. Any information concerning them will be supplied on request.

### BOOKS RECEIVED

**THE TREATMENT OF INJURIES TO THE NERVOUS SYSTEM.** By Donald Munro, M.D., Surgeon-in-chief, Department of Neurosurgery, The Boston City Hospital; Associate Professor of Neurosurgery, Boston University School of Medicine. 284 pages with 47 figures. Price \$7.50. W. B. Saunders Company, West Washington Square, Philadelphia 5, Pa. 1952.

**CULDOSCOPY.** A New Technique in Gynecologic and Obstetric Diagnosis. By Albert Decker, M.D., Clinical Professor of Gynecology and Obstetrics, New York Polyclinic Medical School and Hospital. 148 pages with 50 figures. Price \$3.50. W. B. Saunders Company, West Washington Square, Philadelphia 5, Pa. 1952.

**SEX AFTER FORTY.** By S. A. Lewin, M.D., and John Gilmore, Ph.D., with introduction by the Rev. Dr. Russell L. Dicks, professor of Pastoral Care at Duke University. 200 pages, with nearly 100 illustrations. Price \$3.50. Medical Research Press, 100 Park Avenue, New York 17, N. Y. 1952.

**THE HUMAN PELVIS.** By Carl C. Francis, M.D., Assistant professor of Anatomy, Department of Anatomy, Western Reserve University, Cleveland. 210 pages with 61 illustrations, including three in color. Price \$5.00. The C. V. Mosby Company, 3207 Washington Blvd., Saint Louis 3, Missouri. 1952.

**PHYSICAL DIAGNOSIS.** By Harry Walker, M.D., Professor of Clinical Medicine, Medical College of Virginia, Richmond, Va. 461 pages with 126 illustrations. Price \$8.00. The C. V. Mosby Company, 3207 Washington Blvd., St. Louis 3, Mo. 1952.

**PHARMACOLOGY IN CLINICAL PRACTICE.** By Harry Beckman, M.D., Director, Departments of Pharmacology, Marquette University, Schools of Medicine and Dentistry; consulting physician, Milwaukee County General Hospital and Columbia Hospital, Milwaukee, Wis. 339 pages with 152 figures. Price \$12.50. W. B. Saunders Company, West Washington Square, Philadelphia 5, Pa. 1952.



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# *Opinions From Here and There*

Prepared for your information by the Committee on Public Policy and  
Legislation of the Indiana State Medical Association

## **Making Ends Meet**

The old problem of making ends meet, the National Association of Machinists has discovered, is tougher than ever. Wages are going down—that is, wages after taxes. And the machinists lament they are being tithed to death.

The Union has just figured out that a member with a wife and one child who earns \$80 a week is, under the present tax bill, having \$8.60 of it taken away by the tax collector before the envelope crosses the pay window. The machinists feel pretty bad about it.

So do we. We feel worse because the setting down of bare figures is only the beginning of the story. That more-than-a-tithe figures out to pretty nearly \$450 per year, which is \$450 that a machinist cannot use to buy medical care for his family, a washing machine for his wife, or save for his old age, as he feels right for his needs. What may be more pressing, it is \$450 he cannot use to meet the rising cost of things he needs to live now.

But, if he is unhappy about it, we hope the machinist gets some consolation from the fact that if he can't spend his \$450 his government will spend it for him. That is what he—or at least the union leaders—asked for. The record of the national labor unions in supporting big government budgets (for everything from aid to Greeks to aid to the farmers) has been remarkably consistent. And what the unions have asked the government to spend, the government has had to take away from the union members, one way or another.

The machinists' weekly publication, which front paged the tax bite, did not remind its readers what the government was spending. Actually, the machinist's government was spending in the first hundred days of this fiscal year at the rate of about \$1,900 per second. That means that each second of the day the machinist's government was spending roughly \$477 more than the average per capita income of the machinist and all his fellow workers. So the machinist should be surprised that it costs him \$450 per year?

Indeed, he can take some more consolation from the fact that his tithing isn't as heavy as might be and as it is likely going to be tomorrow. For since in spite of the tithing taxes his government is still

spending more than it gets from him, and there's a bigger bite yet ahead. If there's no respite, the government has to take the balance away from him, too, either through a still deeper tax bite or by robbing him of part of the value of the dollars he's permitted to keep.

"Economy," observed the machinists' weekly news editorial, "was one of the favorite catchwords of the 82nd Congress." Well, for many Congresses past it's been nothing more than a catchword, and the machinist is beginning to find out that as long as it remains so, he is one of those who's caught. (Editorial, *Wall Street Journal*.)

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## MEDICAL AND HEALTH BUDGET OF FEDERAL SECURITY AGENCY\*

Office of Vocational Rehabilitation .....	\$ 22,250,000
Food and Drug Administration .....	5,600,000
Children's Bureau .....	28,600,000
Bureau Public Assistance .....	1,000,000,000
(The following operate under the Public Health Service)	
Tuberculosis Control .....	8,240,000
Venereal Disease Control .....	9,850,000
Assistance to States—General .....	16,150,000
Communicable Disease Control .....	5,919,750
Engineering, Sanitation, Industrial Hygiene .....	3,700,000
Alaska, Disease Investigation, Control .....	1,107,500
Building and Facilities, Cincinnati, Ohio .....	300,000
Hospital Construction Grants .....	75,000,000
Grants for Hospital Construction .....	59,700,000
Hospital Construction, Administrative Expense .....	1,200,000
Hospitals and Medical Care .....	33,688,000
(Note—This sum will be used for operational cost and maintenance of hospitals and health services in caring for American seamen, Coast Guard and Public Health Service personnel, federal employes injured at work, leprosy patients and narcotics addicts.)	
Foreign Quarantine Service .....	3,065,000
Office of Surgeon General .....	3,170,000
National Institute of Health .....	59,030,750
National Cancer Institute .....	17,887,000
Mental Health Institute .....	10,895,000
National Heart Institute .....	12,000,000
Dental Health Institute .....	1,650,000
National Institute of Health—General .....	16,598,750

\* \* \* \* \*

### All This and Dishwashing Too!

General Eisenhower recently exclaimed in a campaign speech that the Federal Government has undertaken to do just about everything for the families of America except help with washing the dishes.

The General does not quite realize how far the government has gone. The federal bureaucracy does indeed offer to help with the dishwashing chore.

It has published a 32-page booklet entitled, "TOOLS FOR FOOD PREPARATION AND DISHWASHING." This is put out by the Bureau of Human Nutrition and Home Economics of the U. S. Department of Agriculture and may be obtained by sending 10 cents to the Superintendent of Documents, Washington, D. C.

Among other comforting thoughts the booklet assures the nation's housewives that dishwashing need not be a disagreeable task if they have the right equipment. To begin with, says the booklet, they should have a dishpan. On this point it further advises,

"You will want a pan large enough to accommodate your dishes, but it must also fit into your sink, if that is where you use it."

It also discloses that there are round dishpans, oval dishpans and oblong dishpans. Doubtless American women will be grateful for this vital piece of intelligence.

\* For the fiscal year ending June 30, 1953.



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The booklet is a fairly elaborate one with credit lines given to individual bureaucrats for preparation, layout, artwork and photography. Obviously the cost of writing, editing, printing and distributing the booklet far exceeds its ten-cent selling price. Any such excess, of course, is made up by the taxpayers.

While the information given in the pamphlet might prove useful to one who is confronted with kitchen chores for the first time, this question might be asked, Has all the household education which has been handed down from mother to daughter in America for generation after generation reached such a low estate that the Washington bureaucracy must now step in and take over such instruction?

**"Of Shoes—and Ships—and Sealing-wax—Of Cabbages—and Kings."**

It should interest General Eisenhower and Governor Stevenson and other candidates for national office to know that government publications designed to help American families live useful and happy lives run the gamut from buying men's suits to taking care of household rubber, and from posture in housework to cultivating gardenias. Here are a few of the titles of currently available pamphlets:

**"MEN'S PREFERENCES AMONG SELECTED CLOTHING ITEMS"** (191 pages). This one contains the astonishing information that most college men wear the same weight underwear the year round, while those with a grammar school education tend to wear heavy underwear in the winter and light in summer.

**"RICE PREFERENCES AMONG HOUSEHOLD CONSUMERS."** This one takes most of its 101 pages to answer the question, "What would you say are the main reasons why you use rice?"

**"HOUSE CLEANING MANAGEMENT AND METHODS"** (22 pages, 10 cents) makes the profound observation that "water, especially warm water, is a good cleansing agent."

**"HOW TO READ THE NEWS"** (27 pages, 15 cents). This contains the suggestion that the reader keep a daily score-sheet on the number of minutes he spends reading the comics, editorials, ads, sports, foreign news, etc.

**"METHODS AND EQUIPMENT FOR HOME LAUNDERING"** (40 pages, 15 cents). This informs the little lady, among other things, that "ironing consists of smoothing out the wrinkles in a fabric and drying out the dampness, which aids in the smoothing process."

**"HOLD ON TO YOUR TEETH"** (8 pages). The inference of this one could be that the Internal Revenue Bureau might try to take them from you too.

**"HOW TO CHOOSE AND USE DRIED PRUNES,"** a folder.

**"CLARA GIVES BENZOL THE RUN AROUND"** (8 pages).

**"ELECTRIC LAMPS THAT YOU CAN MAKE"** (8 pages, 5 cents).

**"SLIP COVERS FOR FURNITURE"** (26 pages, 10 cents).

**"FOOD FOR TWO,"** a folder.

**"USE WRENCHES THE SAFE WAY"** (13 pages, 10 cents).

**"EAT A GOOD BREAKFAST,"** a folder.

**"HOW TO TAILOR A WOMAN'S SUIT"** (24 pages, 15 cents).

And so on down an endless list.

Sometimes the Government Printing Office meets itself coming back. For instance, it has published a booklet on how to destroy cockroaches and another on how to breed them.

Federal bureaus have also published several pamphlets instructing Americans how to operate on a family budget. These stress the need for living

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within one's income. Some may question the propriety of Uncle Sam offering instruction in this particular subject, since the Federal Government itself has lived within its income in only three years of the last 22. One of the chief reasons why American families are having household budget trouble these days is that so much of their income has to be paid out in taxes to finance Uncle Sam's profligacy.

### Are These Things Necessary?

Now it is doubtless true that many of these and other government publications contain information which proves helpful to someone. But just how necessary is it at this time of staggering tax burdens for federal bureaus to perform as mother's little helpers in such an extensive fashion?

For one thing, are there not other agencies, including private ones, which are better equipped to prepare, publish and distribute much of the information the government is trying to offer to American families? There are, for example, a great many universities, agricultural colleges, women's magazines, science publications, food processors, textbook publishers, trade associations, manufacturers, retailers and so on which disseminate such information every day in prodigious quantities.

There is evidence of much needless duplication. The Department of Agriculture, for example, has published at the taxpayers' expense a 24-page illustrated booklet on "TURKEY ON THE TABLE THE YEAR ROUND." Yet at the same time, the National Turkey Foundation, a private institution, distributes to consumers a superior 32-page booklet of its own, entitled "TURKEY—EVERYDAY AND HOLIDAYS," which anyone may obtain without charge. It is better written, better illustrated, gives more useful information to the cook, and costs the American taxpayer not a cent.

It is questionable whether the government is justified in publishing booklets on how to use electrical appliances such as refrigerators, washing machines and vacuum cleaners when manufacturers of these appliances print and distribute the same kind of information to all who buy these things or are thinking of doing so. The electrical appliance industry is well equipped—and appears most willing—to carry on its own educational campaign along these lines.

### The Serious Side

To the extent that all these federal efforts constitute a sincere desire of government bureaus to serve the people in ways which will justify their existence, they deserve criticism only with respect to excesses.

But there is a more serious side, one to which the printing and issuing of mother's little helper booklets is only incidental. It is this: One of the objectives of the left-wing planning group which has long been entrenched in the Federal bureaucracy is to contrive ways of making people feel more and more dependent on government for their daily living. This objective was stated by the late Harold Laski, British Socialist, in his blueprint for achieving State Socialism in this country. Laski said:

"The first step of all is to awaken the American people to a sense of the positive character of the State. They *must be made to realize* the intimate way in which its activities alter the inner fabric of their lives . . ." (underlining ours).

The left-wing planners have worked assiduously in following through on Mr. Laski's proposal. If the American people desire to avoid having State Socialism thrust upon them, they may well begin to consider ways and means of working out their family and community problems with a minimum of reliance on the central government in Washington.—*Federal Spending Facts.*

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# THE JOURNAL

OF THE

## INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

ISSUED MONTHLY *under Direction of the Council*

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NOVEMBER, 1952

NUMBER 11

## THE ETIOLOGIC DIAGNOSIS OF ENDOGENOUS UVEITIS

T. F. SCHLAEGEL, Jr., M.D.\*

*Indianapolis*

THE thesis of this paper is that the etiologic diagnosis of uveitis depends mainly on the knowledge and clinical acumen of the ophthalmologist. A knowledge of the various syndromes is of greater help than laboratory and skin tests. Such an etiologic diagnosis has become of vital importance since the introduction of such potent but dangerous drugs as Cortisone and dihydrostreptomycin.

The ophthalmologist's first step is to classify the condition as granulomatous or nongranulomatous. If such a classification can be made, the battle of diagnosis is half won (Table 1). Differential diagnosis is not always easy, since after repeated attacks nongranulomatous uveitis may simulate the granulomatous type, and since the criteria in Table 1 are not absolute one has to consider all the signs and then make up his mind. The absence of Koeppe nodules and greasy K. P. in an anterior uveitis does not rule

out the granulomatous causes, since in almost half of such cases medium-sized lymphocytic K. P. are observed.<sup>2</sup>

### Granulomatous Uveitis

COMMON CAUSES	UNCOMMON CAUSES
Tuberculosis	Virus infections
Syphilis	Fungus infections
Sarcoid	Lymphogranuloma inguinale
Brucellosis	Histoplasmosis
Toxoplasmosis	Leprosy

### Tuberculosis<sup>4</sup>

Since tuberculosis is the cause of about three-fourths of the cases of granulomatous uveitis,<sup>2</sup> the mere classification of a case as granulomatous points the finger of suspicion at tuberculosis. The diagnosis is made difficult by the fact that the clinical picture may take many forms. It is simplified some, however, if the ophthalmologist will carry in his mind the known facts of infection, allergy and immunity. These three factors must be considered in every case since the lesion is proportionate to—

number and virulence of the bacilli x allergy.  
systemic immunity

Pure allergic reactions are rare. An example is the uveal flare-up with an excessive dose of

\* Department of Ophthalmology, Indiana University School of Medicine, Indianapolis, Indiana. From the Uveitis Clinics of the Indiana University Medical Center and the Indianapolis General Hospital. Presented before the Residents' Conference in Ophthalmology, January, 1952.

TABLE 1

The differential diagnoses of granulomatous and non-granulomatous uveitis. Each feature is not absolute or diagnostic in itself. The decision rests on the picture as a whole.

## GENERAL FEATURES

<i>Granulomatous</i>	<i>Nongranulomatous</i>
1. Tends to affect entire uvea.	1. Tends to affect anterior uvea.
2. Insidious and chronic.	2. Acute onset with short course (3-6 weeks).
3. Tissue destruction followed by nodular overgrowth.	3. No tissue destruction until after several attacks.
4. Usual type in children. <sup>1</sup>	4. Most common ages 20-40 years. <sup>1</sup>

## ANTERIOR SEGMENT

<i>Granulomatous</i>	<i>Nongranulomatous</i>
1. Insidious and mild.	1. Acute onset of severe inflammation.
2. Nodules superficial or deep in the iris.	2. No nodules in the iris.
3. Nodules on the iris (evanescent).	3. No nodules on the iris.
4. Greasy exudates on the lens.	4. May be heavy fibrinous exudate but no greasy exudates.
5. Mutton fat K. P. (greasy and large).	5. Small, non-greasy K. P.
6. Slight flare.	6. Intense flare.
7. Few cells in A. C.	7. Many cells in A. C.
8. Posterior synechiæ.	8. Posterior synechiæ only after several attacks.

## POSTERIOR SEGMENT

<i>Granulomatous</i>	<i>Nongranulomatous</i>
1. Common in choroid.	1. Rare in choroid.
2. Heavy vitreous veils.	2. Generalized clouding and fine punctate opacities rather than heavy veils.
3. Choroidal focus characterized by exudation and by <i>satellite lesions</i> with reactivation.	3. Choroidal focus characterized by subretinal edema.

tuberculin. Such a flare-up is distinctly non-granulomatous in character. There is a sharp onset with iris edema and intense aqueous flare. The course is short with quick subsidence of inflammation and minimal residue.<sup>3</sup> Usually uveal tuberculosis is due to actual invasion by the *Mycobacterium tuberculosis*. After infection, the future course of the lesion is generally due to the systemic immunity and tissue allergy which may be present. Because of these factors, three broadly different types of tuberculosis may be recognized:

1. Childhood, 2. Adolescent, 3. Adult. This simple classification is based not on the age of

the patient but on the degree of allergy and immunity usually shown by these three age groups.<sup>3</sup>

1. In the *child* where the infection may be primary, and in the Negro where susceptibility is often great and immunity low, infection is usually followed by slowly progressive disease. Later, the rapid development of tissue allergy results in acute inflammation with exudation and caseation. Examples are progressive conglomerate tubercle and severe diffuse choroiditis.

2. *Adolescents* may develop a secondary infection on top of a previously developed marked tissue allergy and well-developed systemic immunity. Tubercle bacilli incite a sharp reaction but the infection is controlled by the systemic immunity. Examples are acute tuberculous iritis and acute circumscribed choroiditis. The bacilli are often not destroyed when the primary lesion is controlled but lie dormant in the tissues. With a fall in systemic immunity, the disease again becomes active. The fresh exacerbations originate at the edges of a former lesion (*satellite lesions*) (fig. 1).

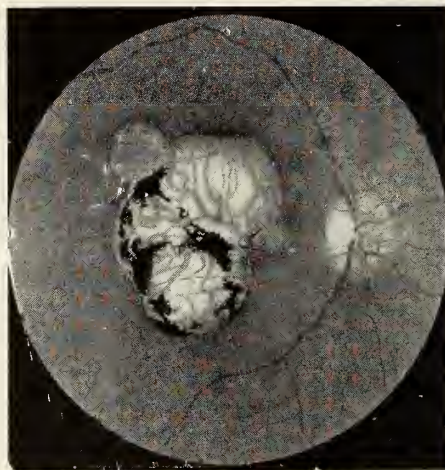


Fig. 1. Satellite lesion at the edge of a former lesion (granulomatous choroiditis). (Woods, A. C.: *Endogenous uveitis*, Amer. Acad. Ophth. and Otolaryng., Omaha, Douglas, 1949.)

3. In *adult* ocular tuberculosis, there is a declining sensitivity and the immunity may be high or low. This group develops the long drawn-out chronic uveitis with its exacerbations and remissions, the process frequently never becoming entirely quiescent.

In both the adolescent and adult forms, there may occur the solitary tubercle of the choroid often with an initial surrounding zone of capil-



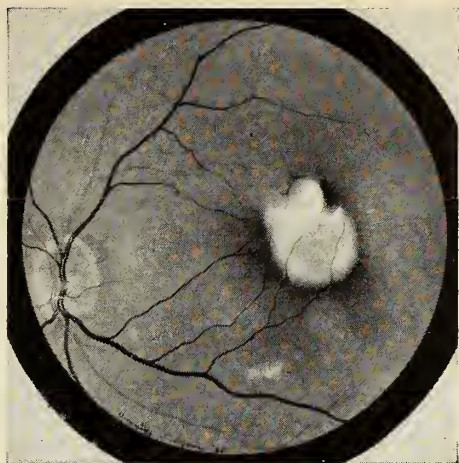


Fig. 2. Solitary tubercle of the choroid with exudation and hemorrhage. (Woods, A. C.: *Endogenous uveitis*, Amer. Acad. Ophth. and Otolaryng., Omaha, Douglas, 1949.)

lary hemorrhage and later localized exudation (fig. 2). These usually heal by hyalization, leaving an elevated white mass.

#### DIAGNOSTIC METHODS:

For a diagnosis of tuberculosis the ophthalmologist is forced to rely on the indirect evidence of from four to six points:

1. The clinical picture.
2. The exclusion of other possible etiologic factors.
3. The demonstration of a systemic reservoir.
4. The tuberculin reactions.
5. The rebound phenomenon after discontinuance of cortisone therapy.
6. The flare-up with overdose of tuberculin.

(1). In some cases the *clinical picture* is almost characteristic (tuberculomas, miliary tubercles of the iris and solitary tubercles of the choroid). In the majority of cases, the possibility of ocular tuberculosis is suggested by the type and course of the disease in relation to the patient's age and tuberculous status.

(2). *Other Etiologic Factors*: If there is no evidence for any of the other recognized infectious granulomas, the diagnosis is simplified.

(3). *Systemic Reservoir*: This is least important for in only about 50 percent of all patients with presumptive ocular tuberculosis are there evidence of old pulmonary infection found on radiographic examination, since the focus is usually deep in the mediastinum and not visible

to x-rays. If the usual antero-posterior plate is negative, lateral plates may disclose a shadow.<sup>3</sup>

(4). *Tuberculin Hypersensitivity*: The meaning of the tuberculin skin tests is not well understood and has impeded rather than aided the etiologic diagnosis of uveitis. Contrary to popular opinion, the determination of the degree of anergy is important, since anergy to O. T. is characteristic of sarcoid, histoplasmosis, and 30 percent of the cases of tuberculosis uveitis<sup>4</sup> (table 2).

Cases of proven ocular tuberculosis are encountered where there is either only a low grade cutaneous sensitivity or complete cutaneous anergy. In the Mantoux reaction, one is estimating only the skin sensitivity. What the ophthalmologist is primarily interested in is the ocular sensitivity. Unfortunately, one can only estimate the degree of ocular sensitivity by the inflammatory reaction and the presence of necrosis and caseation. Although the ocular sensitivity tends to go up or down with the skin sensitivity, an old focus of tuberculosis in the eye may keep the ocular sensitivity up while the skin sensitivity is low or absent. An acute tuberculous uveitis, however, will usually demonstrate more than ordinary skin sensitivity to tuberculin. Such high skin sensitivity is confirmatory evidence of the tuberculous nature of an acute uveitis.

From the practical clinical standpoint: *if the cutaneous tuberculin reactions are low, the test is neither of positive nor of negative value. Unfortunately, some 30 percent of ocular tuberculosis falls in this latter category.*

(5). *The rebound phenomenon after discontinuance of cortisone therapy*: Cortisone is apparently *contraindicated* in tuberculous uveitis. In some cases of tuberculous uveitis, discontinuance of cortisone is followed by a tremendous productive inflammation with giant K. P., large iris nodules, and even the formation of tuberculomas bursting through the anterior surface of the iris. Fortunately the few cases we have seen have responded well to bed rest, dihydrostreptomycin, promizole and tuberculin desensitization.

(6). *The flare-up with overdose of tuberculin*: The flare-up of a uveitis after an overdose of tuberculin is obviously of diagnostic import-

TABLE 2  
The degree of cutaneous sensitivity indicated by O. T. skin tests.

Dose	Reaction	Degree of Cutaneous Sensitivity
0.1 cc 1:100,000 OT	Marked induration or necrosis	Extreme
0.1 cc 1:100,000 OT	Any reaction	High
0.1 cc 1:10,000 OT	Ordinary reaction	Moderate
0.1 cc 1:10,000 OT	Any reaction	Low
0.1 cc 1:1000 OT	No reaction	Practically insensitive
0.1 cc 1:100 OT	Negative	Low degree of Anergy
0.3 cc 1:100 OT	Negative	Moderate Anergy
0.1 cc 1:10 OT	Negative	Complete Anergy

ance but it is to be remembered that such a flare-up is of nongranulomatous character.

Syphilis<sup>4, 5</sup>

In the diagnosis of syphilitic uveitis there are two important points: one is the clinical picture and the other is that a negative serology does not rule out the disease or a positive serology rule it in. The Wasserman is negative in 50 percent of those who develop uveitis after inadequate treatment and this recidive type is frequently associated with neuroretinitis. Also, the blood test may be negative in the uveitis of late syphilis. The general history and physical examination are important.

Syphilis is a *rare* cause of chorioretinitis and then as a late secondary manifestation.<sup>5</sup> Syphilis rarely produces the common disseminated form but is a common cause of the diffuse type or Forster's areolar choroiditis. There is an early punctate haze in the posterior vitreous, the occurrence of grayish yellow areas of hemorrhage scattered throughout the posterior fundus with a tendency to spare the macula and give a partial or complete ring scotoma. Periarterial

streaking often develops along some of the retinal arterioles.

A small number of cases of secondary syphilis show roseola of the iris which are discrete nests of dilated capillaries. Sometimes they are evanescent and sometimes they progress to small papules or larger nodules. In Table 3 are listed the types of syphilitic uveitis based on the stage of general syphilitic involvement, with incidence of occurrence, usual type of inflammation and the prognosis.

The uveitis of late syphilis almost invariably involves the entire uveal tract with an extension to the cornea giving a final picture of kerato-uveitis. There is a marked tendency to secondary glaucoma, cataract, and ultimate phthisis bulbi.

DIAGNOSTIC METHODS:

1. The clinical picture.
2. Proper relationship of the clinical picture to the stage of syphilis.
3. Exclusion of other etiologic factors.
4. Favorable response to antisyphilitic therapy.

TABLE 3  
The incidence of, usual form and prognosis of uveitis in the various stages of syphilis.

Stage of Syphilis	Incidence of uveitis	Usual Form	Prognosis
Early (secondary stage) -----	4.5%	Iritis -----	Good
Recurrent (secondary stage) -----	10.0%	Iritis -----	Fair
Late (secondary stage) -----	Uncommon	Diffuse choroiditis -----	Fair
Late (tertiary stage) -----	3.0%	Panuveitis with keratitis -----	Poor

Solitary granulomata may be found at any stage and tend to appear early.



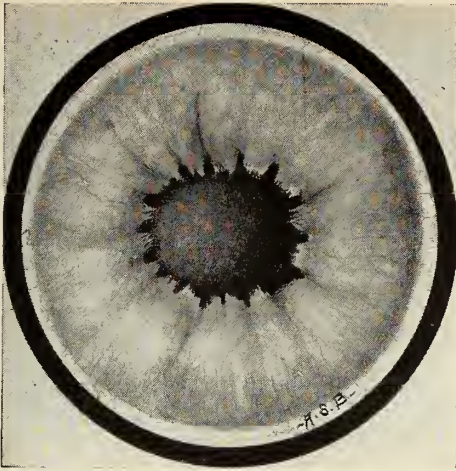


Fig. 3. Thickening of iris with formation of indefinite folds in a case of recurrent brucella iritis. (Woods, A. C.: Endogenous uveitis, Amer. Acad. Ophth. and Otolaryng., Omaha, Douglas, 1949.)

#### Brucellosis<sup>4</sup>

Uveal brucellosis has only recently been recognized. Its recurrent character leads in the iris to a thickening and the formation of indefinite folds (Fig. 3). In one-half of the cases, and especially early in the disease, the uveitis is clinically nongranulomatous in character. The uveitis is not usually acute, however, and persists somewhat longer than does the acute nongranulomatous, allergic iritis attributed to bacterial hypersensitivity.<sup>3</sup> Each attack tends to clear spontaneously. The ocular exacerbations may be synchronous with or follow the periodic fever and lassitude or they may occur without constitutional symptoms. There are no iris nodules and, although the keratic deposits become larger with time, they are usually not of the typical mutton fat type.<sup>3</sup>

In the choroid, brucellosis takes a disseminated and rather characteristic form (fig. 4).

*Diagnostic Methods:* Only occasionally in chronic brucellosis is one able to obtain a positive blood culture.

The diagnosis of brucellosis is suggested by:

1. The clinical picture.
2. Recurrent attacks of low grade fever or lassitude and malaise.
3. History of ingestion of raw milk, raw milk products or handling of cows, pigs or their meat.
4. Exclusion of other etiologic factors.
5. Associated nummular keratitis.<sup>3</sup>
6. Positive serologic and cutaneous tests.

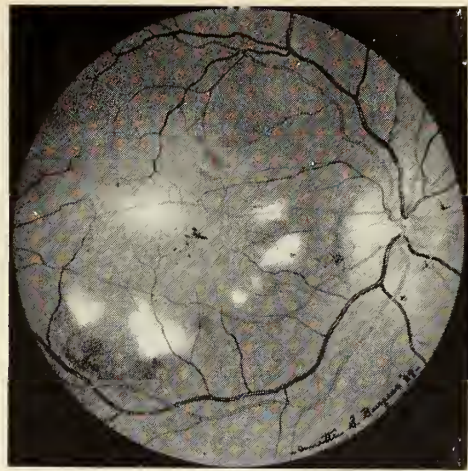


Fig. 4. Disseminated brucella choroiditis. (Woods, A. C.: Endogenous uveitis, Amer. Acad. Ophth. and Otolaryng., Omaha, Douglas, 1949.)

*Tests:* In acute brucellosis the *agglutination titer* is high but in the chronic stage it may fall to a low or zero reading. Thus, in the *chronic stage* of the disease, a titer of over 1:40 may be diagnostic.

*Cutaneous reactivity:* 0.1 cc. of brucellergen is injected. The test becomes positive usually in the chronic stages and appears to be of *considerable diagnostic value*. In chronic ocular brucellosis the skin sensitivity is usually high. The one fallacy in all these tests is that they indicate only that the patient has had brucellosis. They do not indicate that the patient now has the chronic form of the disease but, in most cases, they probably indicate the continuance of a low grade chronic infection.

#### Sarcoid<sup>4, 6</sup>

Forty-five percent of all sarcoid patients have involvement of the eye and 50 percent of these, involvement of the uvea, mainly the iris. The inflammation is usually low grade. The iris typically, but infrequently, contains large nodules (fig. 5). These nodules are usually larger and pinker than those of tuberculosis and unlike them the vascular network tends to invade the nodules. When these nodules absorb, the surface of the iris returns to normal, unlike those of tuberculosis or luetic gumma which leave an atrophic area. In the choroid the disease is less frequent. Sarcoid nodules in the choroid are small and yellowish, producing a superficial choroiditis. Their location may be *perivascular* much like that of miliary tuber-





Fig. 5. Sarcoid nodules of the iris. (Woods, A. C.: *Endogenous uveitis*, Amer. Acad. Ophth. and Otolaryng., Omaha, Douglas, 1949.)

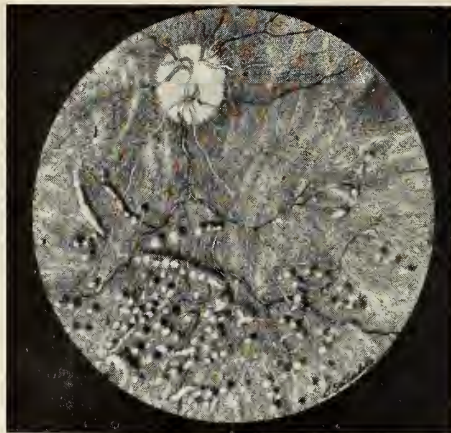


Fig. 7. Vitreous bodies in sarcoid. (Landers, P.H.: *Vitreous lesions observed in Breck's sarcoid*, Am. J. Ophth. 32:1740-41, 1949.)

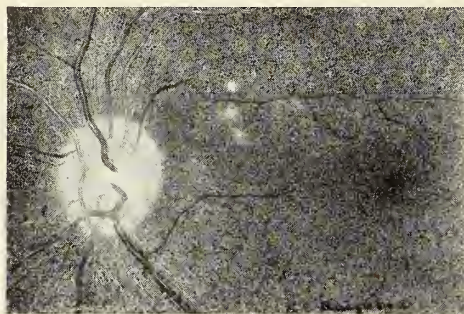


Fig. 6. Sarcoid nodules in the choroid. (Woods, A. C.: *Endogenous uveitis*, Amer. Acad. Ophth. and Otolaryng., Omaha, Douglas, 1949.)



Fig. 8. *Toxoplasma* choroiditis with satellite lesions. (Woods, A. C.: *Endogenous uveitis*, Amer. Acad. Ophth. and Otolaryng., Omaha, Douglas, 1949.)

culosis (fig. 6). Landers<sup>7</sup> has described a new clinical sign of sarcoid. In three young Negro patients, he observed in the dependent portion of the vitreous discrete grayish white spherical (occasionally tubular) bodies which persisted even after the uveitis had become quiescent (fig. 7). They varied in size from dots to one-third disc diameters and tended to simulate a string of pearls. They cast shadows on the retina and did not change position.

The course of sarcoid is usually benign and chronic. Occasionally sarcoid is acute, accompanied by mild fever and sometimes involvement of the parotid—the picture of uveo-parotid fever. When it involves the lacrimal and salivary glands it assumes the picture of Mikulicz's syndrome.

Sarcoid is usually seen in young adults, especially Negroes in whom it is six times more common than in whites.<sup>3</sup> The lymph nodes are moderate in size, firm, rubbery, discrete, movable

and painless. The skin of the lids may be involved with millet-seed like nodules.<sup>3</sup> The suspicion of sarcoid is always aroused in any nodular form of iritis or an unexplained nodular disturbance in the lids or ocular adnexa. This suspicion is investigated by a search for other manifestations of the disease:

- \*1. Glandular enlargement.
2. Cutaneous nodules.
- \*3. Pulmonary changes at the hylus, especially radiating into the lower folds.
4. Long bone changes.
5. Anergy to tuberculin (a positive reaction to a solution no weaker than 0.1 cc. of 1/100 O. T.).

\*In a series of 15 cases the ocular lesions occurred predominantly in association with pulmonary lesions and glandular involvement. Woods, A. C., and Guyton, J. S.: *The role of sarcoid and of brucellosis in uveitis*, Tr. Amer. Acad. Ophth. and Otolaryng., March-April, 1944, p. 12.



6. Laboratory findings: leukopenia, eosinophilia, early monocytosis, false positive Wasserman, elevated serum calcium, elevated NPN and blood urea nitrogen, elevated serum globulin tending to reverse the A/G ratio.
7. Positive biopsy of a superficial sarcoid lesion or an enlarged gland or tonsil.

In a typical case, sarcoid presents little diagnostic difficulty; however, sarcoid is notoriously a spotty disease. The eyes may show the only visible changes and not all lymph glands show the characteristic changes. Therefore, the suspicion of sarcoid may remain in a case of nodular iritis when other manifest causes can be eliminated, even though the biopsy of one or more lymph glands is negative.

### Toxoplasmosis

Since the chorioretinitis of toxoplasmosis is perhaps exclusively limited to prenatal infection,<sup>8</sup> we will consider it only briefly. The important diagnostic signs are: 1) chorioretinitis, 2) hydrocephalus, 3) cerebral calcification, 4) convulsions. The presenting symptoms frequently are epileptiform convulsions and diminished visual acuity.

The *chorioretinitis* is bilateral and usually at the posterior pole. Small satellite lesions may surround the principal foci (fig. 8).

If this congenital chorioretinitis is associated with cerebral calcification, the chances are approximately 9 to 1 that serologic tests will prove it to be due to congenital toxoplasmosis; on the other hand, if it is not associated with cerebral calcification, the chances are approximately 9 to 1 that it is not due to toxoplasmosis.<sup>8</sup>

When first discovered in children under 15 years of age, the possibility of its being a healed, congenital toxoplasmic lesion can be entertained when the serums of both the mother and the child contain toxoplasmic antibodies, even of low titer, because the incidence of such antibodies in normal children under 15 years of age is less than 10 percent. Since after the age of 15 the incidence of toxoplasmic antibodies in the normal population rises abruptly, it is more difficult to make a diagnosis on serologic grounds after the age of 15.

### Histoplasmosis

Krause and Hopkins have recently reported the first case of histoplasmosis with ocular involvement.<sup>8</sup> The case was discovered when after a routine skin test for histoplasmosis there was an exacerbation of an old central chorioretinitis.

The usual diagnostic criteria are:

1. Pulmonary calcification without other evidences of tuberculosis.
2. Anergy to tuberculin.
3. Positive cutaneous reaction to histoplasmin (false positives occur).
4. Agglutination test.
5. Inoculation of guinea pig with patient's serum.
6. Culture of sternal puncture for *Histoplasma capsulatum*.

### Virus Diseases

There are certain signs which suggest virus infection:

1. Aphthous ulcers.
2. Pleocytosis of the spinal fluid.
3. Vitiligo, dysacusia, alopecia

Although viruses *per se* do not produce a typical picture, the following virus diseases will cause uveitis:

1. Herpes zoster.
2. Herpes simplex.
3. Lymphogranuloma venereum.

There are two other syndromes apparently due to viruses.

4. Uveoencephalitis.
  - a. Harada's disease
  - b. Vogt-Koyanagi syndrome
5. Sympathetic ophthalmia.

The diagnosis of the uveitis of *herpes* is based on the corneal and skin lesions. There may be characteristic eruptive vascular lesions on the iris corresponding to those on the skin (herpes iridis). After 6 to 12 months, these leave small white atrophic scars (vitiligo iridis). Another characteristic feature is hyphemia, although hyphemia is also seen in the iritis of gonorrhea and erythema nodosum.

*Lymphogranuloma venereum* occasionally produces iritis but usually as a complication of a severe keratoconjunctivitis.

*Uveoencephalitis*: Cowper has combined Harada's disease and the Vogt-Koyanagi syndrome into one entity, uveoencephalitis, because in both

conditions meningeal and uveal involvement occur and the signs of each overlap.<sup>10</sup>

a. *Harada's disease*<sup>11</sup> has the triad of uveitis, retinal detachment and pleocytosis of the spinal fluid. There is a sudden diffuse, yellowish edematous opacity over the whole of the fundus proceeding to funnel-shaped detachment. After several weeks, the detachment becomes flatter until the fundus assumes its normal color except for irregularly placed pigment spots. Vision may return to normal. During the first two or three weeks, there are headache, loss of appetite, nausea and vomiting but as the changes in the fundus reach their height the systemic symptoms disappear.

b. *The Vogt-Koyanagi syndrome*<sup>11</sup> consists of a bilateral uveitis with alopecia, vitiligo, poliosis and dysacusia. The uveitis is generalized and frequently leads to detachment. The alopecia areata, which is a patchy baldness of hair, eyebrows and lashes, occurs invariably. Poliosis (graying of the hair) is present in 90 percent. Vitiligo and temporary deafness occur in about half the cases. Occasionally general symptoms indicating meningeal involvement occur.

*Sympathetic ophthalmia*: This bilateral granulomatous uveitis usually results from wounds involving uveal tissue. Perforating wounds account for 65 percent, operative wounds for 25 percent, and the remaining 10 percent are due to subconjunctival scleral rupture, perforating corneal ulcers and necrotic intraocular malignant melanomas. Of the operative wounds more than half follow cataract surgery. The second eye becomes involved rarely before two weeks. Most of the cases develop between the fourth and eighth weeks, but the possibility remains indefinitely.<sup>11</sup> Recently Schreck has produced some evidence that the causative agent is a virus related to the Rickettsia group.<sup>12</sup> Wood's intracutaneous test for hypersensitivity to uveal pigment is of little diagnostic or prognostic significance.<sup>13</sup>

#### Nongranulomatous Uveitis<sup>4</sup>

If one accepts the premise that nongranulomatous uveitis is an allergic reaction to bacteria or their soluble products, the diagnostic problem involves the demonstration of this specific hypersensitivity. *The enormous complexity of the problem is apparent when one remembers that*

*the number of bacteria pathogenic for man is legion and it is theoretically possible that non-pathogenic bacteria may also produce a specific hypersensitivity.*

There are certainly two groups of organisms which can be incriminated — the streptococci (mainly beta) and the gonococci. For many decades ophthalmologists have recognized the frequency with which acute iritis complicates rheumatoid arthritis and follows chronic gonococcal infections of the genito-urinary tract or gonococcal arthritis. It has also been recognized for a long time that nongranulomatous iritis is often associated with an acute systemic infection or with a chronic focus of infection.

*Organisms cultured from patient*: When Woods's involved method of skin tests is not available, resort must be had to autogenous vaccines. Sometimes the history leads us to the correct spot for a culture; for example, when a uveitis flares up with an attack of upper respiratory infection, the nose, throat and sinuses should be cultured.

How will we know whether an organism cultured from some remote focus plays a role in the uveitis, since many types of organisms can be cultured from anyone? This is a good question and deserves a good answer. One clue is the history. If a patient's attacks of uveitis coincide with flare-ups of the focus, we have good evidence of the importance of such a focus. Another method is to determine the patient's skin sensitivity to the autogenous vaccine from the focus. If the sensitivity is high and if it is higher than the reaction of normal controls to the same vaccine, we have further evidence of its importance. Weaker confirmation is obtained when there is improvement with therapeutic desensitization. In case an overdose is given and the uveitis flares up, unwanted but valuable confirmatory evidence is gained. If the antistreptolysin test is positive, streptococci are incriminated.

*Gonococcal iritis* occurs only when the disease has spread to the deep urethra. It is a complication of chronic prostatitis or vesiculitis and never occurs during the acute stage of anterior urethritis. It occurs weeks or months after the infection and is usually associated with involvement of the joints. The iritis may take different forms, the most typical being a fibrinous, gela-



tinuous exudate in the anterior chamber. Sometimes the extreme hyperemia of the iris leads to hyphemia.

### Some Miscellaneous Types

A. *Endophthalmitis phacoanaphylactica* should be suspected when a uveitis follows any traumatism to the lens or lens capsule which would permit the absorption of lens protein. A latent period for the development of sensitivity is necessary if the lens capsule of either eye has not previously leaked lens protein.

B. *Phacotoxic uveitis* is provoked by the direct toxic action of lens material rather than by an allergic reaction to it (e.g., Morgagnian cataract). The lens may be hypermature only posteriorly and thus easily missed. The back of the cornea may be covered with large, irregular, lardaceous precipitates composed of macrophages.<sup>14</sup> The treatment is intracapsular lens extraction.

C. *Rheumatoid arthritis*: A nongranulomatous uveitis is commonly associated with rheumatoid arthritis, occurring in about 10 percent of cases. The incidence of iritis in Still's and in the Marie-Strumpell disease is higher than in ordinary rheumatoid arthritis, frequently reaching 50 percent.<sup>15</sup>

D. *Postvaccinal uveitis*: According to Rosen<sup>16</sup> there is no cardinal group of symptoms for the uveitis and other ocular conditions following vaccination for small pox. The diagnosis rests on the very definite incubation period of 10 to 12 days.

E. *Heterochromic cyclitis (of Fuchs)*: This relatively common cyclitis begins insidiously in one eye and runs a quiet course for many years without many of the gross signs of inflammation and without pain. The iris on the involved side becomes rarified. Keratic precipitates are common and the lens tends to become cataractous.

### Conclusions

1. *The etiologic diagnosis of endogenous uveitis depends mainly on the knowledge and clinical acumen of the ophthalmologist.* A thorough work-up of the patient is very desirable but necessitates that the ophthalmologist be aware of the significance of the various tests.

2. An etiologic diagnosis is becoming ever more important with the advent of newer therapeutic agents. These potent drugs should not be used in a shotgun manner.

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### Discussion

**Dr. J. M. Masters:** There were many things in ophthalmology not well understood 20 years ago and the subject of uveitis is no exception. Although treatment of the condition was a common problem, as it is now, some forms of the disease were not as well defined as now and others, while perfectly described, had an unknown cause. Because of this limited knowledge of the etiology, the correlation between uveitis and other generalized diseases was sometimes un-

recognized. For example, sarcoidosis and brucellosis were almost unknown, although uveoparotid fever (Heerfordt) and Mikulicz's disease had long been identified as clinical entities. Naturally much had to be learned about sarcoidosis before this 'old' disease could be connected with it. That brucellosis could be a cause of uveitis only time and experience could prove. Even now it is hard to be sure of this relationship in any given case.

Toxoplasmosis was an unknown disease and has only fairly recently provided an explanation for some cases of central retinal degeneration in children formerly assumed to have resulted from "intrauterine chorioretinitis of unknown cause," "hemorrhage with secondary degeneration," etc.

Beyond herpes zoster and simplex, the relationship to virus infection was practically unknown. Lymphogranuloma venereum is a 'new' disease and strongly indicates, although without positive proof, a relationship to uveitis and other ocular inflammations such as keratitis and conjunctivitis. Harada's syndrome and the Vogt-Koyanagi syndrome are two forms of uveitis associated with involvement of the central nervous system and possibly of virus origin.

Of the nongranulomatous forms of uveitis, the concept of endophthalmitis and phacogenetic uveitis had not developed, although the "toxic effect" of lens material in the eye was frequently discussed.

The relationship to chronic joint disease was well known, although perhaps not as clearly as now. In general, I believe that a review of texts such as that of DeSchweinitz will show that the description of the various common forms of iritis and uveitis are as accurate as

those now given, although perhaps not as well catalogued as to type. Recent classification into granulomatous and nongranulomatous forms of uveitis is unequivocal and provides a definite clinical approach to the problem.

**Dr. G. S. Rubin:** Everybody has given granulomatous uveitis patients cortisone in which the rebound phenomenon did not occur and the eye got better. In the cases that we have seen in this institution there is a much higher percentage of negative skin tuberculosis in granulomatous uveitis than 30 percent. That's one point I'd like to be discussed. In my observation many patients with tuberculous uveitis do not have positive skin reactions to high dilutions of tuberculin.

**Dr. Schlaegel:** We don't get the rebound phenomenon as often as we would expect. This is a point that needs elucidation. Either we are not seeing as many cases of tuberculous uveitis as we think we are or all cases of tuberculous uveitis treated with cortisone don't develop the rebound phenomenon.

When you speak of anergy to tuberculin you should mean no reaction to 1:100 or 1:10 OT. An individual is not anergic if he has a reaction to 1:1000 OT. I would consider a positive reaction to 1:100,000 as indication of high skin sensitivity. If such a high skin sensitivity is found in the presence of a severe acute granulomatous uveitis, I would consider such a skin reaction confirmatory evidence of a tuberculous etiology. For a uveitis of the ordinary severity, however, I would not be swayed from making a diagnosis of tuberculous etiology if complete anergy to 1:10 OT were found in an individual who would not be expected to have a high degree of allergy to tuberculin.





# THE DIAGNOSIS OF CARCINOMA OF THE BREAST—EARLY AND LATE

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*St. Louis*

**T**HE early diagnosis of carcinoma of the breast resolves itself actually into the early recognition of the presence of a breast lump or other evidences of pathology within the breast parenchyma. The actual diagnosis is a histologic one and must be made on excised tissue. Carcinoma of the breast in its earliest stages very seldom will present reliable physical evidence of its true character. Most frequently it will present itself simply as an irregularity in the breast parenchyma, an area of altered consistency or altered surface contour,—a “lump.” Therefore, the title of this paper could quite justifiably be altered to “The Early Recognition of Breast Pathology, and the Diagnosis of Cancer.” It is true that a clinical diagnosis of carcinoma in its very early stages can be made with a fair degree of accuracy by experienced examiners and it behooves us to be as complete in our interpretation of clinical findings as possible. However, “a fair degree of accuracy” leaves far too great a chance for error and the point must be emphasized that simple recognition of the lump is of far greater importance than any guess as to its nature.

The normal breast varies tremendously in the degree of lobulation, in the size and thickness of the parenchyma, in the amount of subcutaneous and interlobular fat, and in the prominence of the underlying ribs. To identify a localized area of early pathological change in such an organ requires painstaking care. The examination may be complicated, as it so often is, by a patient apprehensive over the possibility of cancer and quite convinced before the examination begins that a lump exists. With such influence from the patient and with varying degrees of localized pain and tenderness to further complicate matters, the examiner must exercise great control

not to let these extraneous factors influence the interpretation of the findings of his exploring finger tips. Does or does not palpable pathology exist in this breast? Upon the answer to this question may depend the early diagnosis of cancer, the life of the patient and the reputation of the examiner. Allowing for only the remarkable exception, any identifiable, localized area of palpable change in contour or consistency should be subjected to biopsy or excision for microscopic study and diagnosis. This dogmatic statement is made deliberately in order to shift emphasis from the problem of differential diagnosis of breast pathology on clinical findings alone. It is true that a clinical differential diagnosis should always be attempted, but the most experienced physician will be wrong 30 to 40 per cent of the time (1). This margin of error is too great to allow the differential diagnosis to influence the choice of treatment, except in those cases in which the diagnosis may be clarified by other factors such as the history of previous excision of a benign lesion, or by a multiplicity of lesions in one or both breasts (2). Emphasis *must* lie on the early *recognition* of pathology, not on its identification. Identification must be histologic. To follow any other course will result eventually in the distressing experience of seeing a malignant tumor spread and metastasize under observation.

How, then, can these early pathological changes be identified with accuracy? A part of the answer lies in the careful systematic examination of the breasts of every female patient seeking the counsel of a physician. The importance of the general practitioner and of the obstetrician and gynecologist in this regard is obvious. These physicians have an opportunity to identify a great amount of breast pathology in its early stages. One gynecologist of my acquaintance has been successful for sometime in finding three or four unsuspected carcinomas of the breast yearly in his private practice. This

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could be multiplied a thousand fold if all breast examinations were done meticulously.

### Self-Examination Important

Before discussing the details of breast examination it should be recognized that the majority of patients will have made their own diagnosis of a breast lump. This discovery is usually made accidentally, but as result of the educational campaign of the American Cancer Society and other organizations, is more and more frequently the result of deliberate self-examination. Self-examination is a cost free method of health insurance available to every woman. Monthly or bimonthly, careful self palpation of all quadrants of the breast will go far toward the early recognition of cancer of this organ. It hardly seems necessary to point out that once the lump is discovered the patient should seek the advice of a physician. All the teaching and propaganda in the world will probably not succeed in eliminating the bizarre flight from reality experienced by the occasional patient who, having found a lump, ignores it and does nothing in the hope that it will go away. Self-examination should continue to be taught to the end that every woman reaching maturity will not only understand that a breast lump demands the early attention of a physician, but will also have been instructed in the careful examination of her breasts as part of her personal hygiene and self care. Instructions to the patient should also include a warning as to the importance of an asymmetrical change in the size or appearance of the breast, skin dimpling and nipple retraction or ulceration, since all of these findings may indicate carcinoma that is not demonstrable as a palpable mass.

The history of a breast abnormality can be of distinct aid in indicating a possible diagnosis. Although it is the aim of this presentation to emphasize the importance of early physical findings, there are features in the history that will be of distinct diagnostic value. The knowledge that other members of the patient's family have had breast cancer may be most significant. A history of previous pyogenic infection requiring surgery or the previous excision of breast tumors can shed light upon the nature of subsequent pathology. Abnormalities of the menses and of lactation, the history of a bloody nipple discharge,

the habitual appearance of premenstrual engorgement and nodularity of the breasts, all these factors must be sought out not only for their possible diagnostic value, but because eventually they will add to the sum total of our knowledge of cancer of the breast.

The physical examination of the breast will be effective in direct proportion to its degree of systematization and thoroughness. There can be various methods by which the breast is systematically examined. However, the routine described by Haagensen (3) can serve as an excellent model for the procedure.

*Supraclavicular and Axillary Regions.* With the patient in the sitting position and facing the examiner the supraclavicular and axillary regions are very carefully palpated. It is important that the pectoral muscle be relaxed as the axilla is being examined. This can be accomplished by supporting the arm of the patient with one hand of the examiner.

*Inspection of the Breast.* The next step in the examination is a very careful inspection of the breast for signs of asymmetry, changes in contour, edema, retraction of the nipple or retraction of the skin. To facilitate a search for abnormalities the patient's arms should be elevated above the head, and then placed on the hips with pressure in order to contract the pectoral muscles. These maneuvers may bring out early retraction signs indicating the presence of an underlying neoplastic lesion. The nipples are carefully inspected for signs of erosion or encrustation and for evidence of asymmetry or retraction.

*Palpation.* Palpation should first be done in the supine position with the arm on the side to be examined elevated and placed under the head. This flattens the breast on the chest wall and makes it possible to palpate the breast parenchyma directly with a minimum of density. A pillow placed under the shoulder of the side being examined will facilitate the flattening of the breast on the chest wall. Palpation of all quadrants of the breast systematically should be done with the flat surface of the fingers using gentleness and care. The entire extent of the breast parenchyma must be very carefully palpated in this manner and by so doing it is possible to pick up discrete tumors of a very small



size. It is good practice to re-examine both axillae with the patient in the supine position and again with the pectoral muscle completely relaxed through support of the patient's arm. Although palpation of the breast is most satisfactorily done with the patient in the supine position, occasionally valuable additional information can be obtained in patients with thick and pendulous breasts if they are examined upright with the breast dependent. In this position the breast parenchyma can be grasped between the fingers and some tumefactions in the central portions of the breast and beneath the nipple may be made more easily identifiable.

*Retraction Signs.* It can be assumed that a carcinoma of the breast in its very early stage may not present the signs of retraction of the skin or nipple, and the fibroblastic tissue reaction which results in the formation of these evidences of carcinoma may be undeveloped. However, at times these signs can be detected in association with very small areas of tumefaction and they may be of great value in helping the examiner decide whether pathology actually exists or not. When present, retraction signs are of very great importance. On the other hand, the absence of retraction signs in association with a palpable nodule means absolutely nothing in eliminating the diagnosis of carcinoma. Retraction and dimpling of the skin, retraction and flattening of the nipple, shrinkage of the breast and asymmetry as a result of attachment of tumors to the pectoral fascia are all the result of proliferation of fibrous tissue in response to the presence of the neoplasm. This does not mean that retraction signs cannot accompany fibrous tissue proliferation resulting from other causes. However, the phenomenon is so predominantly in favor of the diagnosis of carcinoma that when present this diagnosis has to be assumed until proven otherwise. This principle holds even in the absence of a palpable mass in association with the signs of retraction of the skin or nipple.

Evidences of skin attachment can be demonstrated by various maneuvers. Proper lighting during the examination is of the greatest importance since the formation of shadows on the surface of the skin may be the only means by which minimal retraction may be demonstrated. Changes in position of the breast by elevation of the arms, leaning forward, or through manipula-

tion may exaggerate the skin attachment and make it evident. Contracting the pectoral muscle by having the patient press on the iliac crest can demonstrate attachment of a tumor to the pectoral fascia by causing it to move with the movement of the muscle.

*Edema.* Edema of the skin of the breast in association with carcinoma can hardly be termed a diagnostic sign. It can more appropriately be classified as an indication of the extent of carcinoma since it results from extensive permeation of the subepidermal lymphatics by malignant cells. With plugging of the lymphatics the skin itself becomes edematous and the openings of the hair follicles on the surface of the skin become exaggerated pits, resulting in the characteristic peau de orange appearance.

*Nipple Ulceration.* Ulceration, erosion, and eczematoid lesions of the nipple may be a fairly early sign of an underlying carcinoma. It is not infrequent for the erosion of Paget's disease to be present for many months without underlying tumefaction being demonstrable. Although such nipple lesions can result from other things the chance of the underlying pathology being carcinoma is so great that all should be biopsied and the diagnosis established by the demonstration of the typical intradermal Paget carcinoma cells.

All the characteristic clinical findings indicating carcinoma can be duplicated by lesions of a benign nature. Pyogenic infections, fat necrosis, tuberculosis, cysts of the breast, all may show changes in consistency, skin and pectoral fascia attachment, asymmetry and nipple retraction which is indistinguishable from that caused by cancer. These refined clinical findings are of chief importance in simply indicating that pathology exists in the breast, rather than as an indication of the nature of the pathology. Once it is decided that pathology exists we can guess its nature on the basis of the detailed clinical findings. This guess is an academic exercise preceding proof of the nature of the lesion by excision and microscopic study.

What of the patient in whom it cannot be determined that pathology exists? The average patient who is not worried about her breasts and who presents no abnormality to physical examination is no problem. On the other hand, the patient who comes to a physician feeling that

she has discovered a lump in her breast and in whom no pathology can be demonstrated on examination may present a very trying problem. Such patients frequently complain of varying amounts of pain and tenderness, the pain may be greatly exaggerated before the menstrual period, and too frequently the patients will have large heavy breasts that are difficult to palpate with certainty and which leave the examiner with an uncomfortable feeling that some deep minimal pathological changes might be missed. What is the responsibility of the physician in a situation of this type? It seems logical that the patient be reassured and then re-examined at intervals until the physician is satisfied as to the absence of pathology requiring surgical intervention. A good practice is to see the patient for the second time in a period of two weeks and then at increasing intervals for another six months or so. This plan makes it virtually impossible for any important pathology to be missed for long. In addition, the patient ends the episode completely satisfied and reassured and in the meantime the physician has had an opportunity to instruct her in self-examination of the breast. It should be strongly emphasized that this period of observation has been to determine the presence or absence of pathology, not to determine the behavior of recognizable pathology present in the breast. A lump should not be watched!

### Apprehension a Problem

Other patients that present a problem as to proper disposal include those with bilateral cystic disease of the breast in which the probable pathology in no one area can really be considered to exceed that elsewhere. In such cases the apprehensive patient who "points" to one area in the breast persistently may influence the surgeon into operating for questionable or minimal palpable findings. Such problems are being presented to the physician more and more frequently as a result of public education, some of which may lead to exaggeration of cancerphobia in an apprehensive patient. Perhaps the dilemma can be resolved for purposes of brevity by stating that definitely palpable pathology or retraction signs are an indication for surgical exploration and biopsy; pain, tenderness and apprehension are not. It is true that some individuals will be frightened by the lay educational programs. This fact does not detract from the overwhelming

good that results from making the public aware of the early signs and symptoms of cancer. All agree that, until better therapeutic agents are discovered than are now at hand, our best chance of improving results lies in earlier recognition and treatment. The public *must* be educated into seeking medical attention early.

In those patients in whom it is decided that a breast lump exists the procedure from this point on is quite simple. It is unbelievable that in our present state of knowledge regarding breast cancer anyone would consider adopting a hands-off policy for any demonstrable breast nodule. However, such is indeed the case. It is a sad commentary on our ability to teach, as well as on the ability of some physicians to read and to learn, that recognized breast lumps are still being shrugged off, ignored, observed, or treated by hormones, antibiotics, infra-red lamps and other wasters of valuable time. It is true that these bizarre efforts are usually the result of complete mis-diagnosis and the interpretation of the clinical findings as indicating that the lesion is inflammatory or a benign cyst or fibroadenoma. The fallibility of the purely clinical diagnosis was forgotten.

Before entering into a discussion of the various methods of obtaining a microscopic diagnosis it is well to consider where and under what circumstances the biopsy should be obtained. A consideration of this problem brings to mind the various medical echelons from the office of the general practitioner, to local hospital, to regional hospital, to medical center. Rather than approach this discussion in a negative fashion it seems most direct to indicate the ideal conditions under which the breast tumor should be investigated. In every case the patient should be admitted to the hospital, and be examined and prepared as for a major surgical procedure. The patient and responsible members of her family should be appraised of the fact that diagnosis cannot be certain until tissue has been examined after removal. They should understand about the possibility of radical mastectomy in order that the surgeon feel no restriction at the time of operation if cancer is found. The breast biopsy should be performed in the operating room under general anesthesia with adequate time and preparation for radical mastectomy should it be indicated. The services of a competent pathologist should be available for frozen section examina-



tion of tissue for diagnosis if necessary. Under these conditions the biopsy can be done, the pathology positively identified and the appropriate course of action can be chosen with certainty and competence.

Biopsies should not be removed under local anesthesia, nor should they be removed in the physician's office. The infiltration of a local anesthetic agent too often will obscure the pathology and make it uncertain as to just what is being excised. Furthermore, no one can be sure of what the effect on curability would be of infiltrating procaine around a small and clinically favorable carcinoma. In addition, it is undesirable to have the patient awake and waiting apprehensively in the operating room while a decision as to the pathological nature of the excised tissue is being made. An exception can be made in the case considered inoperable in which a biopsy for the record under local anesthesia may simplify the procedure.

### Prepare for Major Surgery

The biopsy and excision of breast lumps should not be considered as a minor procedure, but as the preliminary minor procedure of a possible very major one which should be done promptly if indicated. Just where this type of surgery should be undertaken is a matter of available personnel rather than of geographical location. There is no reason that good breast surgery cannot be done in small rural hospitals providing the physical facilities are adequate, good anesthesia is available, the surgeon is competent and has adequate assistance, and the services of a trained pathologist who can supply reliable frozen section diagnoses are available. Too often smaller hospitals, particularly in rural areas, cannot meet all these requirements. Most frequently it will be the services of a competent pathologist that are lacking. Ideally, surgery of the breast should not be attempted unless the various conditions which have such a great bearing on its success are satisfactory. Furthermore, the surgeon's time should be planned in order that there is time for any eventuality. The surgeon who schedules the breast lump excision at the end of a long operative schedule is not being fair to the patient.

The situation frequently arises wherein a patient suspected of having a benign lesion of

the breast is admitted for operation to a small hospital with no pathologist available. The lump is excised and the wound closed. The surgeon is unable to identify positively the nature of the tissue removed on gross examination, but he thinks it is benign. The tissue is mailed to a commercial laboratory in the city and six or seven days following excision of the lump the report is returned from the laboratory indicating that the diagnosis is carcinoma of the breast. The patient is then referred to a surgeon and to the hospital for a radical mastectomy. By the time a bed has been obtained, the surgeon has had an opportunity to check the pathology, and the patient is on the schedule for radical mastectomy another seven to ten days may have passed. This period of time is too long and should not be passed off as of no importance in the ultimate chance of cure of the individual patient. If the time interval between lump excision and radical mastectomy can be cut to three or four days, no one at the present time will insist that the result is jeopardized. However, the principle of the case management described above is all wrong. It is true that the breast lump might indeed have been a benign one, as was suspected. In this case it could be argued that the patient would have been saved the time and expense involved by admission to a hospital adequately equipped. However, would it not be better to gear all cases in favor of the possible malignancy? The patient with the benign lesion would have been cured under either method of management. The patient with the malignant lesion might have been, and frequently is, jeopardized by the method of management described.

### Methods of Biopsy

*Aspiration.* Our use of aspiration biopsy in carcinoma of the breast is limited to the inoperable cases without ulceration in which a microscopic diagnosis is desired for record. If ulceration is present a positive biopsy can usually be obtained easily from the edge of the ulcer. The use of aspiration or Silverman needle biopsy for tumors that are to be subjected to surgery leads to too great a chance for error. Since the lump must be excised and studied in its entirety anyway, there seems little excuse for the limited information supplied by aspiration biopsy.

*Excisional.* Smaller lumps are excised completely for diagnosis. No attempt is made to take

a great margin of tissue. The lump is simply excised with as little manipulation and as neatly as possible. If on gross microscopic section of the nodule it is found to be carcinoma the wound is made completely dry, a gauze sponge is inserted either dry or soaked in formalin or alcohol, and the wound is very tightly closed with a heavy running silk suture. The incision is then covered with collodion or rubber dam held in place with rubber cement. Following this the entire field is re-prepared, gloves, instruments and drapes are changed, and the radical operation is started.

*Incisional.* Larger breast masses, and particularly those located in the periphery of the breast where complete excision would complicate the subsequent radical operation if the tissue proved to be malignant are first approached through a small incision for an incisional biopsy. The incision is so placed and planned that it can be extended if necessary for complete excision of the lump and will interfere as little as possible with subsequent radical operation should this be necessary. The surface of the tumor is approached and exposed, the field is made dry and an adequate wedge section of tissue is removed for study. If this proves to be carcinoma the wound is treated exactly as described above under excisional biopsy. If the diagnosis of carcinoma is not forthcoming the tumor mass is further explored to the point of complete excision if necessary for diagnosis. The arguments that incisional biopsy lead to a greater risk of dissemination of tumor cells are not valid. The simple local excision of malignant lesions leads to the same cutting across of lymphatics and blood vessels in close proximity to tumor and promotes the same chance of dissemination of tumor that is occasioned by incisional biopsy.

A word should be said about simple mastectomy. In my opinion it is so infrequent that definite indications for this procedure arise that I have established the general rule that it should never be done. From this general rule a search can then be made for the rare exception. It can be stated strongly that simple mastectomy has no place in the diagnosis of cancer, and if done in the presence of cancer will greatly jeopardize the results of subsequent radical mastectomy<sup>4</sup>. The microscopic diagnosis of Paget's disease of

the nipple is a diagnosis of carcinoma of the breast and simple mastectomy is unnecessary for verification. Whether or not simple mastectomy will prove to be indicated for any of the benign lesions that are on a hormonal basis and which are associated with epithelial hyperplasia is not clear at this time and will have to be decided by future study.

The diagnosis of carcinoma of the breast may occasionally be made through the recognition of an axillary metastasis in the absence of a palpable breast lesion. If there is no other demonstrable primary tumor, and if the microscopic appearance of a biopsy of the axillary nodule is not incompatible with the diagnosis of metastasis from carcinoma of the breast, a radical mastectomy should be done.<sup>5</sup>

### Summary

In summary the early diagnosis of breast carcinoma will depend upon the early recognition of abnormalities of the breast through self-examination by the patient and careful physical examination by the physician. Physical findings which might lead to some indication of the nature of a breast lump are of insignificant importance when compared to the establishment of the simple fact that a recognizable lump exists. Early biopsy under conditions that will allow a prompt and accurate diagnosis and the institution of adequate surgery should be the therapeutic goal when pathology is demonstrable.

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# IDIOPATHIC HYPOPROTHROMBINEMIA

A Review of the Literature and  
Report of a New Case

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**H**YPOPROTHROMBINEMIA by definition means a deficiency of the prothrombin content of the blood, or an increase of the prothrombin time. The artificial means of creating hypoprothrombinemia is familiar, through the use of Dicumarol, and it is not surprising if the prothrombin time is found to be prolonged in hepatic disease. However, hypoprothrombinemia, of unexplained origin, remains an uncommon entity.

The first recorded case of idiopathic hypoprothrombinemia was reported in 1941.<sup>1</sup> Since that time there have been 19 additional cases reported. We wish to present another case that was discovered accidentally in a patient who was admitted to the hospital for diagnosis and treatment of vaginal bleeding.

*Case Presentation:* The patient, a 63 year old, white female, Gravida VIII, Para VIII, was admitted to St. Elizabeth Hospital, complaining of vaginal bleeding of one week's duration, associated with hematuria for two days.

*Present Illness:* The patient went through a normal menopause 11 years ago. About one year ago, she had vaginal bleeding and a "sore spot" on the mouth of the womb which was cauterized, and followed by an apparent remission of symptoms. Bleeding again developed one week prior to admission, became profuse and continued to the time of admission. This had been associated with hematuria for two days.

*Past History:* Eight pregnancies, the last one 23 years ago. Three of these pregnancies were followed by excessive bleeding which required curettage and vaginal packing. The patient stated that after her first pregnancy, her physician told her that she was a "bleeder." This tendency was also noted following tooth extraction. She had never received blood transfusions.

*Family History:* The father had undiagnosed recurrent hematuria during the latter part of his

life; a living sister and five daughters have very heavy menstrual periods. The grandchildren have no history of abnormal bleeding.

*Physical Examination:* Revealed a rather obese elderly female, not acutely ill and cooperative. Blood pressure, 185/90. The heart and lungs were essentially negative. The abdomen was very obese, and no masses or tenderness were noted. A rather heavy vaginal hemorrhagic discharge was present and pelvic examination was essentially normal.

*Laboratory Findings:* Urinalysis: negative. Serology—Mazzini, negative. C.B.C.: Hgb., 93%; R.B.C., 4,700,000; W.B.C., 6,450. Differential: Neutrophils, 66%; lymphocytes, 30%; monocytes, 2%. The patient was typed Rh negative. Prothrombin Times were run daily and varied from 22% to 28% of normal. (Fig. 4).

*Liver Function Tests:* Icteric Index, 12.6 units; thymol turbidity, 3.51 units; total protein, 6.2 gm.%; albumin, 3 gm.%; globulin 3.2 gm.%; A/G ratio, 0.9/1.0; N.P.N., 39 mg.%; Sugar, 135 mg.%; Bromsulphalein, 6% retention; Hippuric acid, 109.4% of normal; Cephalin flocculation, 2 plus at 48 hours; Cholesterol, 159 mg.%; Bilirubin, 0.1 mg.%. R.B.C. Fragility, within normal limits; Platelet count, 343,000; clot retraction reported as slight in 24 hours; Coagulation time, 7 min. 40 sec.; bleeding time, 1 min. 30 sec.; Corrected Sedimentation Rate, 16 mm./hr.; Bone marrow studies were non-informative.

*Progress:* A working diagnosis of idiopathic hypoprothrombinemia was made. The patient failed to respond to blood transfusions, I.V. vitamin "K", or any other type of therapy. She continued to bleed considerably from the vagina and was taken to surgery for dilatation and curettage, which was followed by vaginal packing. No further bleeding was noted. She re-

ceived a total of seven transfusions (500 cc. each) during her hospital stay, and was discharged on her thirtieth hospital day.

Prothrombin times were done on five members of the immediate family (daughters) and were all within normal limits.

*Follow-Up:* As of November 20, 1951 (eight months after discharge), the patient has shown no recurrence of bleeding tendencies.

*Discussion:* In reviewing the literature, we were able to collect 20 cases, including our own. This number may not be complete since new foreign literature was not entirely available.

The cases were evenly distributed between men and women (Fig. 1). The youngest patient was a five weeks old male, while the oldest patient was an 83 year old female. In spite of the fact that the disease occurs at any age, it is usually first seen in children and young adults. Fifteen of the cases reported were under the age of 30.

The diagnosis was usually precipitated by the onset of bleeding which was classified as epistaxis, hematemesis, hemoptysis, melena, vaginal

bleeding, or the ease of producing hematomas or massive "black and blue spots" on slight trauma. All patients except one gave a prolonged history of bleeding tendencies.

There was a familial incidence of the disease in 12, or 60 per cent of the reported cases. This was manifested by either bleeding tendencies in one or more members of the family or by the laboratory determination of low prothrombin levels.

The bleeding time was normal in 17 patients, or 85 per cent. It was prolonged in only one case and was unreported in the remaining two cases. The clotting time was prolonged in 12 cases, or 60 per cent. The clot retraction time was normal in 13 cases of those reported, and recorded as poor in five (unrecorded in two cases). The platelet count was normal in all cases. The tourniquet test was reported as negative in 11 patients and positive in five. The plasma fibrinogen was normal in all 15 cases reported.

In 1949, Quick<sup>21</sup> presented the classification of hypoprothrombinemia and divided it into

#### REVIEW OF REPORTED CASES

REVIEW OF REPORTED CASES											RESPONSE TO						
AUTHOR	AGE SEX	FAMILIAL INCIDENCE	BLEEDING TENDENCIES	BLEEDING TIME	CLOTTING TIME	CLOT RETRACTION	PLATELETS	TOURNIQUET TEST	PLASMA FIBRINOGEN	PRO- THROMBIN TIME	SAME			VIT. K	WHOLE BLOOD	SERUM	
											A	B	LABILE FACTOR				
J E RHOADS TF HUGH 1951	16 M	NONE	SINCE AGE OF SIX	NORMAL	PROLONGED	POOR	NORMAL	POSITIVE	NORMAL	70-120 SEC				NONE	HEMO- STATIC		
A S GIORDANO 1943	22 M	PRESENT	NOTICED AT AGE OF FIVE	NORMAL	NORMAL	NORMAL	NORMAL	POSITIVE	NORMAL	9 % (SMITH)				NONE	HEMO- STATIC	POOR	
P PLUM S HEINIO 1943	20 F	PRESENT	DETECTED INCIDENTALLY		PROLONGED	NORMAL	NORMAL	NEGATIVE	NORMAL	30.5 SEC. (PLUM)				NONE			
	18 M	NONE	DETECTED INCIDENTALLY		PROLONGED		NORMAL	NEGATIVE		28 SEC. (PLUM)				NONE			
F O MURPHY J K CLARK 1944	18 M	PRESENT	SINCE AGE OF FOUR	NORMAL	NORMAL	NORMAL	NORMAL	NEGATIVE	NORMAL	60-100 SEC. (QUICK)				NONE	HEMO		
L de MARVAL G BOMCHIL 1944	14 F	NONE	SINCE AGE OF 8	NORMAL	PROLONGED	NORMAL	NORMAL	POSITIVE	NORMAL	25-53 % (QUICK)				NONE			
L de MARVAL 1945	23 F	PRESENT	SINCE AGE OF 3	NORMAL	PROLONGED	NORMAL	NORMAL	NEGATIVE		20-25 % (QUICK)				NONE			
F HAUSER 1945	3 M	PRESENT	SINCE AGE OF 3 MONTHS	NORMAL	PROLONGED	NORMAL	NORMAL	NEGATIVE	NORMAL	21-80 % (QUICK)				NONE			
	9 M	PRESENT	NONE	NORMAL	PROLONGED	NORMAL	NORMAL	NEGATIVE	NORMAL	53 % (QUICK)				NONE			
V T AUSTIN H OUAFLER 1945	56 M	NONE	PRESENT	NORMAL	NORMAL	POOR	NORMAL	NEGATIVE	NORMAL	5-92 %				GOOD			
J H LEWIS I J BENNETT 1947	29 F	PRESENT	SINCE AGE OF FIVE	NORMAL	PROLONGED	POOR		NEGATIVE	NORMAL	5-10 MIN	N	D	N	GOOD	GOOD	GOOD	
A J QUICK 1947	1 M	PRESENT	SINCE BIRTH	NORMAL	PROLONGED	NORMAL	NORMAL		NORMAL	19 SEC.	N	N	N	NONE			
	57 M	PRESENT		NORMAL	PROLONGED	NORMAL	NORMAL		NORMAL	19 SEC	N	N	N	NONE			
P S HAGEN C J WATSON 1948	20 F	PRESENT	SINCE AGE OF 8	PROLONGED	PROLONGED	POOR		NEGATIVE	NORMAL	5-10 %	?	D	?	NONE	GOOD	GOOD	
I A HEINDL R O FREIDLANDER 1948	43 F	NONE	SINCE AGE OF 42	NORMAL	NORMAL	NORMAL	NORMAL			4-25 MIN				GOOD	GOOD		
C L CROCKETT D SHOTTON 1949 C G CRADDOCK	8 F	NONE	SINCE AGE OF 2	NORMAL	PROLONGED	NORMAL	NORMAL	NEGATIVE	NORMAL	58-80 SEC.	N	N	N	D	NONE	GOOD	GOOD
G LANOWEHR H LONG 1950 B ALEXANDER	5 WKS M	PRESENT	SINCE BIRTH	NORMAL	NORMAL	NORMAL	NORMAL		NORMAL	1-2 %				N	POOR	POOR	POOR
W F RENNER 1950	83 F	NONE	PRESENT	NORMAL	NORMAL		NORMAL			NO CLOT				NONE	NONE		
J A COVEY J L COHEN 1950 J P PAPPS	44 F	PRESENT	SINCE BIRTH	NORMAL	NORMAL	NORMAL	NORMAL	POSITIVE		25-100 SEC.				POOR			
AUTHOR'S CASE	63 F	PRESENT	AGE OF 14	NORMAL	NORMAL	NONE	NORMAL	NEGATIVE	NORMAL		N	D	N	N	NONE	POOR	

Figure 1. Review of cases reported in the literature.



two major classes, which he called the congenital and the acquired types. In reviewing our case we can quickly eliminate the acquired causes of hypoprothrombinemia. The patient was well nourished and presented no evidence of dietary deficiencies. Her liver function tests were all within normal limits except for increased total globulin and an A/G ratio of 0.9/1.0. She did not manifest the signs and symptoms of cirrhosis, hepatitis, sprue or biliary fistula. She gave no history of use of any of the drugs that are known to cause hypoprothrombinemia, e.g., Dicumarol, streptomycin,<sup>18</sup> salicylates,<sup>19</sup> and more recently para-animosalicylic acid.<sup>23</sup>

The most interesting aspect of this disease has been the numerous different and unending theories as to its etiology. When the first cases were reported, it was only noted that the prothrombin time was prolonged. Quick<sup>29</sup> in 1943, postulated the existence of multiple constituents of prothrombin. He first described a labile factor which disappeared from stored plasma, this he called component "A". Another factor, which was decreased by oral administration of Dicumarol, was called component "B". However, he<sup>30</sup> later showed that the labile factor was different from component "A". The latter was said to be decreased in vitamin "K" deficiencies. Quick's classification of the different components of the prothrombin complex were not accepted as such.<sup>5</sup> Many authors suggested other names for the labile factor. Smith calls it the prothrombin convertibility factor, Owren<sup>24</sup> factor V, Seegars and Ware<sup>28</sup> named it Ac-globulin, and Fantl and Nance<sup>26</sup> the accelerator factor. All these substances seem to be related to the labile factor. The question, "What are the components of prothrombin" still remained an enigma.

In 1949, Quick<sup>31</sup> described three types of hypoprothrombinemia; a first type which was associated with an unknown entity, called labile factor; a second type was due to lack of component "A", which required vitamin "K" for its synthesis; and finally, a third type which was presumed to be due to lack of component "B" and was said to be congenital and hereditary. In the same year Quick<sup>32</sup> and Stefanini asserted that there were two types of hypoprothrombinemia due to lack of component "A". In the first type there was deficiency of both free (or active) and total component "A" and in the

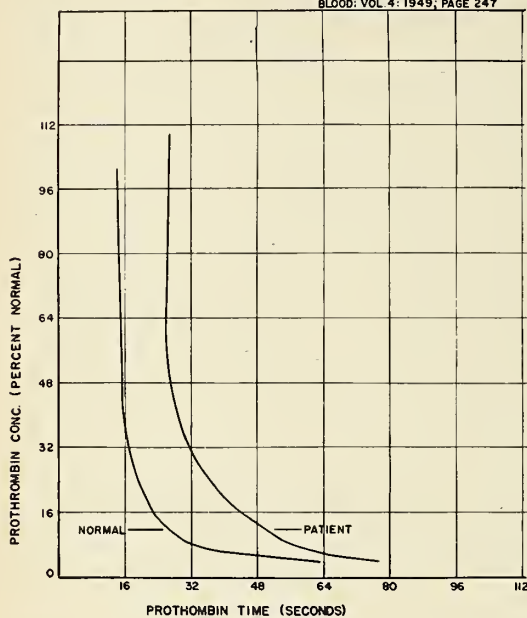
second type the concentration of total component "A" was normal but the active component was deficient. It then appeared that there was an unknown factor responsible for the regulation of the ratio of active to total component "A". Quick<sup>32</sup> suggested that this activator was probably interpreted by other authors as the accelerator or AC-globulin factor. It is the substance that is present in normal plasma which affects the first reaction of clotting,<sup>28</sup> or conversion of prothrombin to thrombin. The quantity is usually sufficient to provide maximum thrombin yield in analysis for prothrombin by the one stage method. A deficiency of this factor would then lead to a low prothrombin titer. Owren<sup>25</sup> as well as Frank, Bilham and Ekren<sup>38</sup> believe that some of the cases thought to be idiopathic hypoprothrombinemia, may be cases of parahemophilia, and that the factor which influences the prothrombin time seems to be one which is isolated from prothrombin-free plasma.

Though there is apparent confusion, it has been shown that what in the past has been referred to as prothrombin in human plasma, can now be divided into at least four factors. To facilitate ease in reporting this case, these factors will be referred to as follows: a) Labile factor, the substance that disappears in stored plasma<sup>29</sup>; b) Component "A", or classical prothrombin which is absorbable by  $\text{Ca}_3(\text{PO}_4)_2$  and requires vitamin "K" for its synthesis; c) Component "B", the substance or substances lacking in hypoprothrombinemia, in which Component "A" and labile factor are present in normal amounts,<sup>31</sup> and finally, d) The accelerator factor of DeVries (SPCA). A deficiency of any of these factors will produce a decrease in prothrombin activity as measured by the one stage method of Quick.

The possibility of hypo-fibrinogenemia affecting the prothrombin time in this case was excluded by noting a normal fibrinogen level. Also, the possible role of clot inhibitors, e.g., heparin, is minimized because of the scarcity of clinical investigation of the part these substances contribute to idiopathic hypoprothrombinemia. The remaining discussion will therefore be limited to the prothrombin complex.

The labile factor and SPCA were found to be present in normal quantities. The former, by the following method: Fresh normal plasma was

## PROTHROMBIN ACTIVITY CURVE

DEVRIES, A., ALEXANDER, B.; GOLDSTEIN, R.  
BLOOD: VOL 4: 1949; PAGE 247

FRESH PLASMA OF PD = 29 secs.

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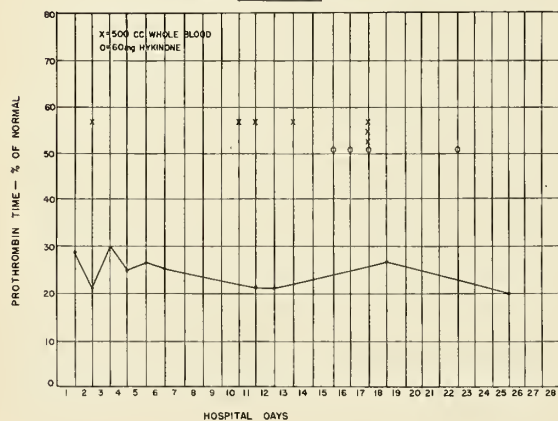
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GUICK, A.J.; ON CONSTITUTION  
PROTHROMBIN. AM.J. PHYSIOLOGY;  
140: 212-220; 1943

mixed with patients' stored plasma, and stored normal plasma was mixed with patients' fresh plasma, with resulting similar prothrombin times.<sup>29</sup> (See Fig. 2). The method of DeVries et al., for determining SPCA levels eliminated this factor.<sup>34</sup> (See Fig. 3).

There was no evidence of component "A" deficiency, as noted clinically. The patient had an apparent adequate vitamin "K" intake, and failed to respond to high doses of parenteral administration of this substance. Also, whole blood and serum had only minimal effect on her prothrombin time (Fig. 4). The laboratory substantiated this. The patient's plasma was mixed in increasing concentrations with  $\text{Ca}_3(\text{PO}_4)_2$  treated normal plasma of decreasing concentrations and also with decreasing concentrations of normal plasma. The former mixture showed a progressive increase in prothrombin time to infinity, and the latter, a progressive decrease to normal prothrombin time values, at equal concentration of the two mixtures, indicating a normal component "A" level. The deficiency then must be one of component "B". (See above).

## Summary

1. Review of the literature reveals 19 reported cases of idiopathic hypoprothrombinemia.
2. There are at least four factors of the prothrombin complex. A decrease in any or all of these will produce an increase in the prothrombin time as measured by the one stage method of Quick.
3. A new case of idiopathic hypoprothrombinemia in a 63 year old white female is presented.
4. This is one of the few cases in which the deficient factor has been shown to be component "B". (See above).

## Acknowledgments

J. M. McFadden, M.D., Pathologist, St. Elizabeth Hospital, Lafayette, Indiana for consultative and technical aid.

Figure 2. Comparison of the prothrombin activity curves in our patient and in a normal individual.

Figure 3. Determination of the labile factor according to the method of DeVries.

Figure 4. Demonstrates failure of the prothrombin time to be influenced by whole blood or vitamin K.



L. C. Smith, M.D., Staff, St. Elizabeth Hospital, Lafayette, Indiana, Physician in charge of the case presented.

Frances Crowell Bessette, Laboratory Technician, St. Elizabeth Hospital, Lafayette, Indiana.

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## "To All My Patients"

*The Vanderburgh County Medical Society has issued an attractive folder to supplement the message on the A.M.A. office plaque which invites patients to discuss fees with their doctor. The printed matter is concise enough to invite easy reading. It discusses briefly how fees are based, what expenses the physician must meet from his gross income, and how doctors' bills may be paid. It is well prepared and will go a long way toward increasing the public's understanding of the financial side of medical practice.*



# THE JOURNAL

OF THE

## INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

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## DIABETES DETECTION

**S** EVEN hundred county medical societies in the United States will take part in the annual diabetes detection drive this year. Forty of the county societies of Indiana have appointed committees to coordinate detection activities in the state.

Diabetes week will be from November 16 to 22. During this time as many organizations as possible will conduct diabetes detection programs for their members. Many schools, factories and other businesses will cooperate.

In addition individuals who are not a part of any group are urged to visit their family doctor for a urinalysis. \*Materials for the performance of a standard test for glycosuria are furnished by the American Diabetes Association. It is hoped that the tests can be performed without charge. The good will which is created by a public service such as this far outweighs the expense.

While everyone is included in the invitation,

there are certain people who are more likely to have undiagnosed diabetes. These are the overweight, and the relatives of known diabetics. Special invitations should be issued for them.

Highlights of the detection drive are:

1. There are probably one million undiagnosed diabetics in the U. S.
2. Many of the undiagnosed diabetics do not have symptoms severe enough to bring them to a doctor early in their disease.
3. Diagnosis and treatment in the early stages of diabetes may make the entire course of the disease less severe and may lower the incidence of complications.

Previous detection drives have discovered from one-half to two or three percent new diabetics. In Marion County last year 92 confirmed cases were found in a group of 5,583 persons tested.

\* American Diabetes Association, Inc., 11 West 42nd Street, New York 36, New York.

## RURAL HEALTH SURVEY

THE Department of Agricultural Economics of Purdue University recently published the report of a health survey made in 1950 in three Indiana counties.

The purpose of the survey was to discover the health and medical care habits of rural families, and to ascertain the opinions of rural people in regard to health matters.

The 20-page report is entitled "Health and Medical Care Practices of Rural Families in Three Indiana Counties, 1950." Copies may be obtained by addressing the Agricultural Experi-

ment Station, Purdue University, Lafayette, Indiana.

The survey was made by interviewing 200 representative families from each of the three counties, Huntington, Hendricks, and Orange. The questions asked were designed to elicit information on many aspects of both curative and preventive medical and health matters.

The report is extremely interesting. It will be of especial interest to anyone studying rural medical care. All physicians will find it informative.

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## VETERANS' HOME TOWN CARE

THE contract which provides veterans' home town medical care was renewed recently. The agreement was made originally in 1946 by the Veterans' Administration and the Indiana State Medical Association. It has been renewed annually ever since. Minor changes, mostly in the fee schedule, have been made on each renewal, but basically the 1946 arrangement has remained the same for six years.

The resulting system has provided office and home medical care for veterans in an eminently satisfactory fashion. It has enabled the Veterans' Administration to furnish care, in cases where hospitalization was not necessary, without the expense of maintaining large out-patient clinics, and with the advantage of preserving a considerable amount of doctor-patient relationship between the veteran and his own family physician.

The program has been administered in Indiana with a high degree of cooperation and understanding on both sides. Difficulties have been so few and far between, so minor in character, and so easily adjusted that they are described by the Veterans' Administration as being practically non-existent.

Patients are sent to doctors of their own

choice. The Veterans' Administration maintains a list of physicians in the state who have signified their willingness to treat patients under the 'home town care' contract. Any physician may make application to the VA to have his name listed. This is not always necessary however, since, if a veteran requests the services of a physician who is not on the list, the VA will authorize the doctor to treat this particular patient. When the veteran does not name the physician of his choice, or when the VA requires an examination for pension, compensation, insurance, or other purposes, the physician is chosen from the list maintained by the VA. The list of participating physicians has remained mostly the same through the six years. Doctors who wish to have their names withdrawn may have this done on their own request.

The volume of work accomplished under this program has remained remarkably constant year by year since 1946. Veterans of WW I and WW II are cared for under this scheme for service connected ailments only. This group is fairly constant in number. Vocational trainees under Public Law 16 received all-inclusive care, and as their number has decreased, veterans of the Spanish-American War have been added.



## THE CLINICAL SESSION OF THE AMERICAN MEDICAL ASSOCIATION

THE annual Clinical Session of the American Medical Association, now in its sixth year, has come to be regarded as one of the most comprehensive and practical of the condensed post-graduate medical education programs available in this country. This year's session, to be held in Denver, Dec. 2-5, will feature clinical and technical exhibits, clinical demonstrations, medical and surgical moving pictures and television, and some 200 review lectures or panels on current progress in obstetrics, pediatrics, cardiovascular and chest diseases, neurology, psychiatry, traumatic surgery, medical therapy, and water and electrolyte therapy. As in previous Clinical Sessions emphasis will be on everyday problems rather than rarities, practical demonstrations rather than theoretical discussions, and survey lectures rather than descriptions of individual research.

The entire Denver program will be held in the city's newly enlarged municipal auditorium, so that visitors can attend a full day's activities without leaving the building. Adequate restaurant facilities will be provided. The technical exposition, in which about 125 drug and equipment manufacturers, food processors, medical book publishers, and other commercial organizations will display their products and services, will be located on the central arena floor adjacent to the registration desks. The 60 scientific exhibits and the clinical demonstrations on fractures, artificial respiration, and obstetric techniques will be situated on the lower level of the new building. The eight separate meeting rooms in which the review lectures will be presented are adjacent to the exhibits.

The program opens Tuesday morning, Dec. 2, with scientific and technical exhibits and medical motion pictures. On Tuesday afternoon and each subsequent afternoon there will be general lectures by speakers of national prominence on

such subjects as essential hypertension, bone tumors, urinary infections in children, parenteral protein feeding, and other basic subjects. Following this, surgical operations will be televised in color from the operating rooms of Denver General Hospital, and special group lectures will be presented by outstanding clinicians and teachers. The television and group lectures will continue on subsequent mornings and afternoons, while a diversified entertainment program will be offered each evening. This will include a concert by the Denver Symphony Orchestra. Since the House of Delegates of the American Medical Association meets concurrently with the Clinical Session, interested visitors will have an opportunity to see this policy-making body in action. A highlight of the program will be the selection of the General Practitioner of the Year from a list of nominees submitted by county and state medical societies from all parts of the country.

Those planning to attend the Clinical Session should make reservation as soon as possible. Application forms for hotel reservations and for advance registration will be found in subsequent issues of *THE JOURNAL*.—*The Journal of the American Medical Association*.

### *Editorial Notes*

Dr. Henry H. Kessler of Newark, N. J., has been presented the first Physician's Award of the President's Committee on Employment of the Physically Handicapped. The award is given annually to the physician who made the greatest contribution during the year to the welfare and employment of the physically handicapped. Mr. Truman explained that he and Vice Admiral Ross T. McIntire, committee chairman, decided on the award in order that "*the doctors of our country could be brought closer into the whole rehabilitation and employment picture.*" Dr. Kessler, an orthopedic surgeon, is director of the Kessler Institute for Rehabilitation and a past president of the National Rehabilitation Association.

# Medical Panorama *by the* ASSOCIATE EDITOR

## PHONY TV M.D.'S

From *The Bulletin of the Los Angeles County Medical Association* for August 7, 1952, we glean the following worthy remarks,—samples of an editorial we should like to reprint in full. If you have not yet “run onto” the practice described below, you should be able to find confirmation via some friend’s TV set. From the half-tones in ordinary “ads” to the technique described below, it has been an easy step,—apparently without objection. But read on:

So-called “Doctors”—complete with white coat and stethoscope—are becoming as common a sight on television these days as Faye Emerson and Arthur Godfrey, and as for the audience,—

Even though the person delivering the persuasive message is only an actor, his disguised appearance is enough to convince them that he is actually a doctor.

\* \* \* \*

Up to the present time, our collective profession has looked upon television’s little masquerade with condescending good humor; however, to this writer, at least, it would seem that our silent approval should

come to a quick end. When the sanctimoniously-disguised actor doles out his advice from the television screen, he is not just an actor to the audience which is listening to him. He is a doctor, and what he says must therefore be true.

We do not allow pharmaceutical houses to dispense drugs detrimental to our patients’ good health. We do not allow advertisers to use our medical journals for the huckstering of questionable products. We even frown on our professions’ *legitimate* representatives appearing on television without prior consent from their local medical society. These points, however, lose logic when we see actors given carte blanche to back up their statements with our experience and public prestige.

By action on a national level—that is, by the Council on Medical Services of the American Medical Association—it is this writer’s recommendation that our tacit approval of television MD’s come to a halt. A letter from each of us to the offending sponsors is one effective means of protest, but the grass-root movement should start with letters to the AMA itself, informing them of our dissatisfaction with the abuse of our professional standards. One way or another, we need such definite action to discourage the present advertising fad.

Interesting little angle, isn’t it?

## Telephone Technique

How is the telephone answered in your office? Brusquely and loftily, or pleasantly and with implication that the patient is important?

Thought given to telephone answering will be immediately helpful in your own relationship with patients, and ultimately in shaping the public attitude toward medicine. For example:

### 1. Initial response to ringing telephone:

WRONG: “Doctor’s office.”

“Just a minute, please.”

“Hello.”

RIGHT: “Doctor Jones’s office, Miss Briarly speaking.”

“Garfield 0-0000” (if there are several physicians using the same number).

“Doctors Jones and Black; may I help you?”

### 2. On making appointments:

WRONG: “I can give you Thursday at two.”

“Doctor can see you Monday morning.”

“Wednesday afternoon is the doctor’s day off.”

RIGHT: “Could you make it on Thursday at two?”

“Monday morning would be a good time if that is convenient.”

“Doctor Jones will not be able to see you on Wednesday afternoon; could you come in Thursday?”

—CALIFORNIA MEDICINE





## President's Page



Fellow Members of the I.S.M.A.:

THE 1952-53 organization of the Indiana State Medical Association became official October 30th and a list of committee appointments is printed in this issue of The Journal of the Indiana State Medical Association. Many are capable, but obviously few can be selected to function on the various committees. However, you will find large committees, whose membership is distributed over the entire State of Indiana. It is disappointing that every member of the State Association cannot be assigned to "do a job" each year. Your enthusiasm and interest would be directly proportional to ergs of work demanded by each assignment. Since this is impossible you, as an individual member, can demonstrate your loyalty by attending each meeting of your county society. Resolve to become a vital force in its arbitrations and activities. Don't wait until New Year's. Complacency is a symptom of inertia, a disease characteristic of too many members of organized medicine. If your district councilor has inertia and because of it does not visit your county society at least once a year, or attend council meetings regularly, then elect a new councilor. The I.S.M.A. is not a hierarchy and your officials are not dictators, but it may seem so to you if you do not attend meetings, become active and get the lead out of your *gluteus maximus*. Gentlemen, we must work and work and work to keep the skeleton of socialized medicine locked behind the door of competition. It is sad but true that in a free America eternal vigilance is still the price we must pay for the privilege of conducting a free enterprise.

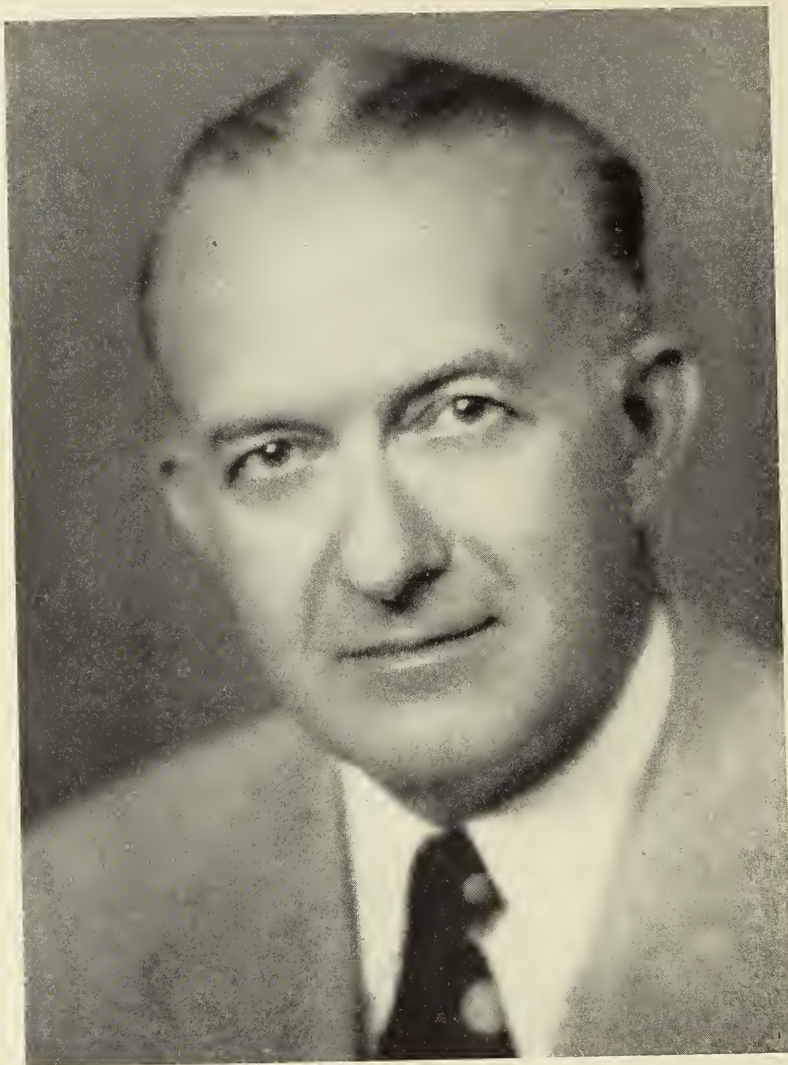
A meeting of all the committee chairmen was held at the Hotel Lincoln Thursday noon, October 30, in order that committee work might function immediately. From you, who have been appointed chairman of various committees and have accepted said responsibility, we would appreciate a committee report by December 20, 1952. If the members of your committee fail to show up when you call a meeting, find out if they desire a replacement. Likewise, we will need volunteers for special committees which future necessities may demand. Let us know who you are and what you desire to do. If you decide that your committee has outlived its usefulness on said assignment, then report a good reason for discontinuing your committee. It is not good business to carry on committees if they are loaded with worn out objectives. Committees should study their objectives in the light of revaluation, and perhaps a re-orientation of these objectives may be forthcoming.

As always, your Executive Committee, your Council, and your House of Delegates, stand ready to consider not only county society problems, but the problems of any and all members of this great medical association in the great State of Indiana. One year hence if we fail to accomplish our objectives we trust you can say, "at least they gave it the old college try."

This next year special emphasis will be directed in behalf of Medical Ethics. Hippocrates, that famous Greek physician, gave us an oath, and a law which have been the basis and guide for the ethics of the medical profession since five centuries before Christ, and

"Your officials heartily agree  
In Nineteen Hundred and Fifty-three  
To promote—constantly, not occasionally  
Medical Ethics."

Paul D. Grimm M.D.



PAUL D. CRIMM, M.D.  
Evansville

PRESIDENT  
INDIANA STATE MEDICAL ASSOCIATION  
1952-53



## PAUL D. CRIMM, M.D.

## PRESIDENT

## INDIANA STATE MEDICAL ASSOCIATION

1952-53

DR. PAUL D. CRIMM, of Evansville, was installed as president of the Indiana State Medical Association on October 30, the closing day of the Annual Session. Part of the after-dinner ceremonies included the presentation of the president's gavel to Dr. Crimm by Dr. J. William Wright, the outgoing president, who in turn received a certificate of merit and the president's plaque from Dr. Crimm.

In his acceptance speech Dr. Crimm lauded medical ethics as a code of principles which has been evolved throughout centuries by a noble and sincere profession. He announced that medical ethics would be the theme of his administration. He commended the study of medical ethics by all physicians and urged them to rededicate themselves to the principles which Hippocrates originated in 450 B.C.

Doctor Crimm was born on December 6, 1893 in Beverly, Ohio. He is the son of a Methodist minister and lived in several towns in Ohio during his youth. He attended High School in Delaware, Ohio, and graduated with the A.B. degree from Ohio Wesleyan University.

After active service in World War I he entered medical school, and received the M.D. degree from Western Reserve University School of Medicine in 1923.

His postgraduate training was in the form of a surgical residency in University Hospital, Cleveland. Following his residency he was hospitalized for the cure of pulmonary tuberculosis, and then served residencies at Saranac Lake and Hartford, Connecticut.

He has been the Director and Chest Surgeon of Boehne Tuberculosis Hospital, Evansville, for the past 23 years. He and Mrs. Crimm are the parents of a daughter and a son, both of whom are attending Indiana colleges.

He was the president of the Vanderburgh County Medical Society in 1935, and has served as delegate to the ISMA and as alternate councilor of the First District. He holds membership in the county, state and national Tuberculosis Associations, having served as director of each, and in 1935 he was president of the state association.

Membership in other learned societies include the National Tuberculosis Association, the American Trudeau Society, The American College of Chest Physicians, the American Association for Thoracic Surgery, and the American College of Surgeons.

Doctor Crimm has maintained an active interest in many community services. He is chairman of the Health and Sanitation Committee of the Evansville Chamber of Commerce. He is Assistant Deputy Director of Disaster Hospital for Vanderburgh County Civil Defense. He is an enthusiastic Rotarian and was District Governor of the 226th District in 1938. He is past-president of the Alpha Kappa Kappa medical fraternity, and is now a member of its international council.

# The Fourth Estate Looks At Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

## A FAITHFUL PUBLIC SERVANT

Dr. William D. Weis, Lake County health officer for 18 years, and city health officer of Hammond from 1908 to 1918, has resigned on the advice of his physician. The 79-year-old physician, dean of the Lake County medical profession, will remain at the post he has so ably occupied until his successor has been selected.

Dr. Weis built a county department of health, second to none in Indiana, out of what had been a part-time political job for a doctor favored by the party in power. Likewise he started sanitation in Hammond restaurants and groceries as the city's fearless health officer who refused to be "shushed."

Born in Cook, on November 28, 1873, Dr. Weis grew up in Crown Point, and in early life learned the machinist trade. After attending high school he entered the teaching profession from which he earned money for his medical education. He served as president of a Hammond bank and helped to develop several real estate subdivisions.

No doctor in Lake County's history has made a greater contribution to public health. When he was appointed county health director the records and supplies were kept in various doctors' offices and one nurse served 10,000 school children. Today, nine nurses serve 19,000 children, and the department of health has become an integral part of the county government and an agency of public education on all matters pertaining to health.

Dr. Weis has done a magnificent job. His retirement is well earned. He has the respect and high regard of the members of his noble profession and the good people of Lake County.

Congratulations to a great general in the war on disease and misery, and a champion of the people in the crusade for sanitation, health and happy living.—*Hammond Times*.

## A SOCIALIST FAILURE

Lord Horder, prominent English physician, speaking to the International College of Surgeons in Chicago, admitted England's national health service is a blunder that lowered efficiency in medical care.

Administered entirely by laymen instead of medical men, it is a demagogic political adventure, intended to gain support of the people rather than serve them.

Dr. Horder had considerable to say about the medical situation in the United States, warning that social medicine should not be attempted for any reason, political or otherwise. After undergoing subjugation at the hands of the British labor-

ites, an ignorant as well as tyrannical lot, it is understandable that he should be alarmed.

American physicians, he said, can avoid the blunder made in England by first putting their own house in order and not, under any circumstances, placing their faith in any political party. "Strive for unity in your own ranks," he advised. "The doctors' disunity is the politicians' opportunity. Medicine is your trust. It is not safe in the hands of the politicians."

Continuing, Dr. Horder declared:

"Think if you could not simplify medical care in the patient's interest. Simplification would spell less expense, and this is clearly the boggy frightening the public and encouraging the politicians to interfere. If the citizen falls for the lure of the welfare state, you may not be able to save him. But at least don't push him in."—*The Terre Haute Star*.

## IN RIGHT DIRECTION

Time was when the family doctor was just that.

He brought the family into the world, and did his professional best to keep it here instead of surrendering it to the hereafter. In addition he often was family advisor, the recipient of confidences and friend. He was paid when it was convenient, which too often was never.

This is an age of specialization and unfortunately this important figure familiar to the American scene appears to be vanishing from the family circle.

Taking his place is a series of highly trained specialists, any one of whom the patient may not see more than once in a lifetime. The result is longer life and a lower mortality rate and a growing gap between doctor and patient. That gap frequently is filled with misunderstandings that never existed when the doctor virtually was a member of the family.

Now Evansville doctors are taking the first step in an effort to restore some semblance of the doctor-patient relationship that is so important to both parties. Showing up in doctors' offices are neat plaques inviting the patient to discuss his health and economic problems with the doctor.

While it isn't likely this ever can restore the affinity that once existed between doctor and patient it could very easily dispel much of the misunderstanding that is proving so disturbing to the medical profession. The doctors certainly are moving in the right direction and we are glad to see it.

—*The Evansville Press*.



## LARUE D. CARTER HOSPITAL TO SERVE STATE'S MENTALLY ILL

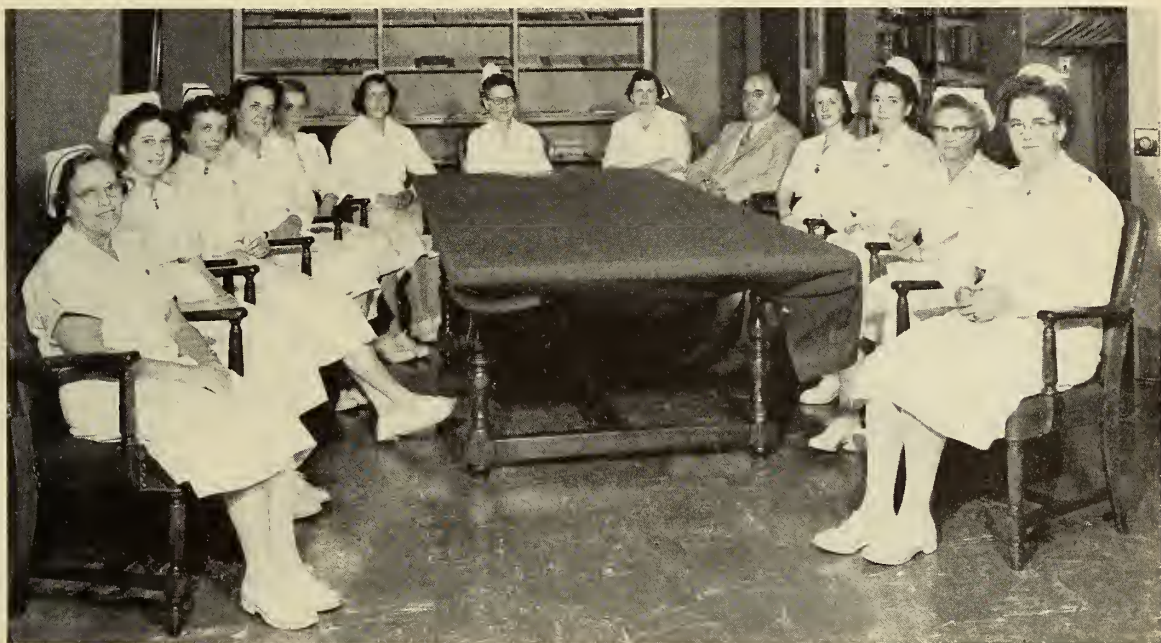
INDIANA'S partial answer to the pressing question of how best to treat her mentally ill—the Larue D. Carter Memorial hospital—was formally dedicated on Sunday, September 28. The staff had been carefully selected and patients received by July 28, 1952.

This 250-bed facility was authorized by the Indiana General Assembly in 1945, the site selected in 1946 and construction started in October, 1949. In accordance with the act of the legislature, building went forward under the supervision of the Indiana Council for Mental Health. All facilities are available for instruction of medical students, student nurses, interns and resident physicians under supervision of the faculty of Indiana University School of Medicine.

The \$5,000,000 hospital was named for Larue D. Carter, M.D., first president of the Indiana

Council for Mental Health and a pioneer in the field of neuropsychiatry. Doctor Carter, who died in 1946, had served as professor of neuropsychiatry at Indiana University School of Medicine and as chief of the neuropsychiatric department at Indianapolis City hospital. For many years he operated Norways Sanatorium. His years of labor and research seeking better treatment for and of the mentally ill placed Doctor Carter among Indiana's most distinguished physicians.

The hospital is planned primarily to teach doctors, nurses, other professional personnel and attendants the most effective means of treating mental illness. Juul C. Nielsen, M.D., a native of Denmark and former superintendent at Hastings State hospital, Nebraska, is medical superintendent.



Supervising nurses consult with Dr. Nielsen, above, in the library of the Larne D. Carter Memorial hospital. This supervisory group makes certain that each patient has best possible nursing care and acts as a teaching faculty to affiliated students in psychiatric training, to nurses taking graduate training and to attendants.

Specialists in psychiatric social service, occupational therapy, psychology and diet round out the staff which has been selected with the knowledge that the quality of the personnel is of prime importance in the operation of a mental hospital.



Pictured above is a front view of the Larue D. Carter Memorial hospital. The entrance leads into the administrative offices. Laboratories, physicians' offices, dining rooms, auditorium and lounge are in the center section with receiving and storage rooms and a loading dock to the rear. Wards for patients are in four wings built at angles to the central section. The hospital is the most specialized of the state's mental institutions.

## IF YOU ARE TAKEN TO A HOSPITAL . . .

A JURY at Hammersmith agreed with the guidance of the Coroner and found that the doctors and nurses in West London Hospital did all they could in using ordinary skill and care, though in vain, to save the life of Joseph Topper, a 22-year-old boy who was reported to have been thrown off his cycle by a shooting-brake driven by an L driver.

Fathers in such cases are emotionally strung-up and Topper's father complained at the inquest. After the accident the boy was suffering from shock and had pain in his shoulder, so the father took him to West London Hospital.

A nurse put them in a cubicle. During a wait of 35 to 40 minutes the boy began to feel faint. The nurse was called: she slapped his face (which the Coroner pointed out was "a recognized method of reviving people") and then told him to put his head between his knees.

### Waiting

The nurse was not to know that the young man had a broken bone piercing his chest wall—for they were still waiting for a doctor.

The father said at the inquest he felt that when he asked the nurse to give his son something it would have been proper to have fetched a doctor.

A woman doctor, Dr. Estelle Mackrell, came and found the young man had a broken collar bone, had an X-ray taken, and the nurse band-

aged the shoulder and said the young man should be brought back next morning.

At seven next morning the father was alarmed at his son's condition, dialed 999 and an ambulance came. The son reached the hospital about 8:10 a.m. He was not seen by a doctor until 9:00 a.m., and the young man died about 2:30 p.m.

The father said that it was not until about 11:00 in the morning that he was told they suspected his son had a punctured lung, and he told the Coroner that if he had been properly X-rayed they might have found the trouble before it was too late.

### Accidents

A Coroner's inquest has gone into the facts and found that there was no negligence. The public will wonder, nevertheless, whether hospitals are properly organized, whether in cases like this such delays are necessary, whether the casual patient coming in from an accident always has the thorough examination his case demands.

We are used to delays and inefficiency in State organizations. Now the State controls hospitals the public will be alarmed if—and we are not now talking about the West London Hospital—bureaucratic bungling and don't-care enter there.

For a life is a life.

—*The Recorder, London, England*



# STATEMENT OF THE I.S.M.A. TO THE PRESIDENT'S COMMISSION ON HEALTH NEEDS OF THE NATION\*

Presented by

J. WILLIAM WRIGHT, SR., M.D., President

**I** TO INTRODUCE myself, I am J. William Wright, Sr., a practicing physician of Indianapolis, Indiana. I am President of the Indiana State Medical Association and I am here in that capacity today.

We appreciate the opportunity accorded our Association to present testimony before this Commission, and upon attempting to limit our remarks to 10 minutes, on just a few days notice, we more and more realize what an impossible task confronts you in attempting to evaluate the Health Needs of this great nation in a period of 12 months. Neither you, nor we, can do this in the time allotted.

In interpreting this subject of "Health Needs" everyone can place a different interpretation upon the phrase, but it should be stated here there shall always be "Health Needs" irrespective of measures taken to solve them. We shall always have with us a group which will not practice good health habits, even if the facilities were free, the same as we shall always have those among us who will not work at gainful employment even though it might be offered them. Therefore, we should admit, the health needs of the nation can never be completely solved, because the public will never permit their being solved in all respects.

I can say without fear of contradiction, there has been no group which has evidenced more interest in the health of the people of this nation than have the physicians, and the medical research scientists. Some would differ with this statement. Taking into consideration the remarks which have been made previously before this commission, and the remarks yet to be made, together with the known facts now on file with the various departments of government, provides conclusive evidence of the profession's sincere interest in the health of our people.

Unfortunately, those who would criticize the profession do so on limited authority. It has seemingly been the pattern of events during the past few years to select those few instances where there is room for legitimate complaint and charge the whole profession with the guilt of the wrongdoings of a few. Yet, I daresay, there is not an organization appearing before your commission, in which similar examples of neglect (or whatever term you might choose to call it) cannot be found among the membership. Therefore, we feel that a more honest appraisal of the facts should be made, in the belief the advancements and the good accomplished will far outweigh the unfortunate.

In our opinion, Indiana is an average state; it has long been recognized as the center of population for the nation. It is composed of all races and creeds, it is both industrial and agricultural, in fact, we have been considered as a true cross section, for many studies made by many organizations.

Indiana, too, has a reputation for solving its own problems, without the necessity of outside interference. We, in Indiana, and I feel I speak for the citizenry as well as the profession of medicine, in making this statement, feel it is still our God-given right to chart our own course, and resolve our own problems in a manner harmonious with our way of life.

I note, your commission has been charged with the responsibility of surveying "Current shortages in health personnel."

In referring to the medical profession, I would like to make it clear there is a difference between health and medical care. Health is a matter of individual responsibility, while medical care is a purchasable commodity. Health is not a commodity that can be purchased with money; health is something only the individual himself can control. Some are endowed with

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\* Detroit hearing, September 23, 1952.

good health, while others less fortunate are created with poor health, and in many cases no matter what is done, the health cannot be restored. If a physician prescribes health-giving measures, and the patient fails or refuses to follow these recommendations, then poor health is the fault of the individual and the individual only; legislation will not change this picture.

The medical profession was the first organization concerned with the subject of health. In Indiana, as has been true in most states, the establishment of our State Board of Health was through efforts made by the medical profession. Indiana is proud of the fact the medical profession of our state was responsible for establishment of the first food and drug act in the nation. In fact, the Federal Government has adopted almost word for word the Indiana law.

Without exception, every organization, presently working in Indiana in an effort to bring better health practices to the people of our state, either through assistance of one form or another, or through programs of education, can show the medical profession either as one of the first supporters of these programs, or that physicians are closely allied as members of their board of control; or active in assisting in carrying on their programs.

There is a wide variance of opinion of what constitutes adequate health personnel, or what constitutes a shortage of personnel. If, in this case, you are referring to physicians, we do not believe there is a dire shortage of physicians in Indiana. The physician population ratio for Indiana is well within the national average. It is a fact that the training of physicians in our state has shown a marked increase during the past few years. Our state school, originally planned to train 86 physicians per year, has for several years been training 150 per year, and now ranks fifth in the nation. It is true, we need more modern facilities for our school, but this problem is being solved by the people of our state. In 1951, the legislature granted \$125,000 for the purpose of blueprinting and planning a new medical training center anticipated to cost somewhere near 6 million dollars. This sum, it is expected, will be granted by the 1953 legislature.

During this period of forced inflation, our school has suffered because its dollars would not go as far. The physicians of Indiana, during

the first six months of 1952, voluntarily contributed over \$50,000 to assist the school through this difficult period. These gifts have permitted the school to maintain salary scales in keeping with the times and permitted the filling of chairs which otherwise might have been left vacant. This effort on the part of Indiana physicians is not a one-time shot—rather, it is geared to multiples of three years.

There are those, too, who claim there is an urgent need for more physicians in the rural areas. The greatest problem we have here is the fact that present government demands for medical personnel does not leave sufficient men to begin to fill some of these purported needs. Yet, in spite of this, there is no person in Indiana suffering from lack of medical attention if the need is made known.

Again, as we discuss the so-called shortages of physicians in the rural areas, we feel there are other shortages in existence also. For example, what has happened to the general stores that dotted the countryside just a few years ago, the hardware stores, etc.? Lack of utilization of these facilities by the residents of rural America has driven them out of business. As transportation has improved, the people have been inclined to travel to the larger centers for their needs, including medical care, and no longer will utilize their local facilities, only when it is inconvenient for them to travel to the larger centers for their wants. Therefore, it becomes a problem for anyone to fulfill the need for any facility, as a matter of convenience. Our economy today, demands a person take in a sufficient amount to permit his existence. Therefore, medical men, too, have migrated to the larger centers where the public travels to transact everyday needs. If the reverse were true, we would not have a shortage of physicians in any community, nor do we have such today, in face of the above facts. We can, however, agree we may have a maldistribution, but this could be solved overnight, if the public itself would change its habits and return to the practice of depending upon the neighborhood communities for its wants.

Indiana has an abundance of health personnel, should you consider those who are working in the field of health either in gainful employment or on a voluntary basis. If we could estimate the number of people involved in the active



work and educational effort of our various agencies, both official and voluntary, then Indiana could cite the ratio of health personnel as being approximately one person in every four.

If you interpret adequacy of local public health units as meaning every community should have a full-time health department staffed with a large corps of specialists in every phase of what we accept as basic essentials of health, then a shortage does exist in Indiana. However, every county in our state has either a full-time or a part-time health department. Many counties have functioning health councils, comprised of those skilled in the field of health and the public at large. Indiana has legislation on the books providing for health departments at the local level, as elaborate as the community might desire. However, few communities have felt they needed a full-time health department and have so signified by their ballots. In other words, Indiana communities properly have the right to determine by ballot their desires in this field.

The present status and adequacy of medical research—Indiana, of course, does not have the elaborate research centers to be found in other sections of the country. Nevertheless, many research projects of note have been and are being carried on within our state. We are the home of one of the world's largest pharmaceutical manufacturers, Eli Lilly and Company. This firm alone has developed many items which have proved helpful to millions of individuals throughout the world. They have been responsible for many drugs which have enabled the span of life to be increased.

Research is constantly being carried on in our large university hospitals and in laboratories throughout our state.

Today, every community in our state is within easy reach of good hospital or clinic facilities. In a recent study, there was no community in the state, which did not have at least one hospital facility within a radius of 20 miles. Indiana communities have been alert and have constructed hospital facilities where they felt they were needed to provide more accessible care. 1,736 new beds have been or are being added to our hospitals. Some of these have been built with the aid of Hill-Burton funds, but as many have been constructed and equipped with local capital, raised totally through local effort. For example, in our state capitol, Indianapolis, we

are presently in the process of raising 12 million dollars for the purpose of constructing new hospital facilities in a section of town now removed, because of traffic conditions, from easy access to present facilities, and for the expansion of existing hospital facilities to care for the rapidly growing population due to the steady expansion of industry in our community.

The next item which you were charged with surveying, namely, "The extent to which people are able to afford adequate medical care, with particular reference to present health insurance plans and their adequacy" really intrigues me. What I am about to say will probably be one of the most disputed statements made before your commission. I make the statement that there is not a person who cannot afford to be sick. The constant attacks upon the medical profession for the high cost of sickness are unwarranted and without foundation. In the first place, there has been no differentiation made between the charges made by the physicians of this nation and the many other factors of expense which are acquired through sickness, such as hospital care, drugs, appliances, etc. Taking only the physician's side of this picture, I repeat, the people of this nation can all afford to be sick, even the percentage which we shall always have with us, who can neither, or who won't attempt to pay for their illness, have adequate medical care available if the need is made known.

It is unfair to charge the medical profession with making the cost of sickness so expensive. Let us take the man working in industry. According to the Indiana Employment Security Division, in September, 1940 the average weekly wage in our state was \$25.66 gross for an average of .659c per hour. At this time, a laborer in the industrial area, known as the Calumet area of Indiana, was charged an average of \$150 for an appendectomy, \$100 for a hernia operation and \$2 for the treatment of a mashed toe or finger.

According to the same source, the average weekly wage in Indiana for this same group today is \$72.72 with an average hourly wage of \$1.723.

Today, the same laborer will pay the same doctor an average of \$200 for an appendectomy, \$100 for a hernia and \$3 for a mashed toe or finger.

In 1940 it took 227.3 man hours of labor to pay for an appendectomy; today, he works 116 hours.

In 1940 he worked 151.5 hours to pay for his hernia operation; today, he works 58 hours.

In 1940 he worked 4.5 hours to pay for a mashed toe or finger; today, he works 1.7 hours.

Let us take a farmer, for example, and compare his cost of physicians' services a few years ago and today. In Indiana, we have a great habit of judging values on the prices of corn and hogs.

In 1940 the average going rate for an appendectomy was \$100, hogs sold in Indiana according to the United States Production and Marketing Administration, on September 14, 1940 for \$6.76 per hundredweight, and on September 13, 1952 for \$20.08 per hundredweight. Therefore, in 1940, it took 1,480 pounds of hogs to pay for an appendectomy. Today, the average going rate for this same operation is \$150, yet it takes only 673.4 pounds of hogs to pay for this surgery.

In 1940 it took 160 bushels of corn to pay the \$100 charge, as again, according to the same authority, corn was selling for 63c per bushel on September 15, 1940. Today, with the operation costing \$150 and corn selling at \$1.57 per bushel, it takes less than 100 bushels to pay for the same operation.

I wish to qualify the above statements by stating the charges for physicians' services are taken from a survey made in the highest priced areas of our state, and not in the lower priced areas. In other words, if the comparison was taken from the rural areas of our state, and the industrial comparison was made using our smaller industrial centers we are certain there would have been even greater proof of the economy of medical care today as compared with a few years ago.

It is always amazing to us to hear some criticize the fact that present health insurance plans do neither cover the entire cost of illness nor the total population of our great nation. All cost of illness can be provided if the public is willing to pay the bill. Those who claim we need total coverage of all if we are to be a healthy nation, forget there are many other factors that go into providing health as we use the term—food, clothing and shelter to name a few. Why

then do we not also advocate prepayment plans for those necessities of life because, certainly, medical and hospital care are not the sole guarantors of health. Approximately 25 per cent of the population of Indiana is protected against the unexpected cost of illness by the Blue Cross and Blue Shield Plans alone, this does not take into consideration the thousands protected by other insurance plans. Every person in Indiana has access to a plan of insuring against the cost of sickness, yet many refuse to take advantage of their opportunity.

Even the government has not encouraged its employes to take advantage of these plans. Through making payment of premiums possible by payroll deduction, industry has done that which the government itself has failed to do.

The sixth purpose of your survey—to determine the adequacy of federal, state and local health programs, with emphasis upon the desirable level of such expenditure—is another question upon which all of us can place our own interpretation. It is our feeling that the greatest need today is a constructive educational program designed to encourage the public to consider more seriously their own health and that of their families. In the field of preventative medicine the Boards of Health are doing an outstanding piece of work, if our experience in Indiana can be cited as a criteria. The Boards of Health, together with the many official and non-official agencies working in this field, are most cooperative and all are active in attempting to encourage and conduct active health programs in every community throughout the state.

The problem that appears the most difficult to solve is how to get people to take their health seriously in their everyday life, rather than become interested in health only when they arrive at the hospital or call a physician. People to a great sense do not seem interested in health, although there has been a marked increase in this regard during the past few years. This, I feel, is due largely to the effort being made by our many official and non-official agencies and their educational programs.

It is difficult to teach health to our school children, when, for example, they are not housed in a healthy environment. For example, on a recent tour of some of our schools hardly a washroom was found in which toilet paper, soap, hot and cold running water and towels



were all in evidence; yet, we attempt to teach cleanliness as a basic item of health. Parents and others do not seem to be concerned with poor washroom facilities, yet how can we successfully teach health, when the necessary items for practicing good health are not present? This is not meant in a tone of criticism, rather it is made a part of this record only to show the great problem we have in having people take an interest in the health of themselves and their children.

For years, physical examinations have been advocated as a preventative measure against serious illness. Free X-ray examinations have been given to the public by one of our voluntary agencies, free diabetes tests have been offered by the profession, and a host of other services have been made available to the public in an effort to encourage it to develop better health practices. Our profession has offered speakers to groups to discuss health subjects and various diseases. Yet, in spite of all this effort, very few have taken advantage of these services in an effort to protect their health or to better understand the symptoms of disease.

The Indiana State Medical Association has 42 active committees, all of which concern themselves with some aspect of health. I would like to review for you just what we are doing in our program of assistance to the public in attempting to encourage better health practices.

**BOARD OF APPEALS ON PATIENT-PHYSICIAN RELATIONS.** Established for use by the public in cases in which they feel the physician has overcharged or failed to provide proper care.

**COMMITTEE ON INDUSTRIAL HEALTH.** This committee prepared, published and distributed the first booklet containing instructions for nurses in industry. Requests have been received from throughout the United States and its possessions for copies. It has met with labor representatives, government officials, management and physicians in an effort to encourage better health programs in industry.

**COMMITTEE ON MEDICAL EDUCATION.** This committee utilized for the first time in medical history the telephone to bring the latest in scientific medicine to our membership. Each month, by telephone circuit, our members listen to an hour of discussion by outstanding author-

ities on new developments in medical science. We have, on occasion, had more than 6,000 miles of telephone lines leased for this program.

**COMMITTEE ON PUBLICITY.** Releases weekly a column on health to all the papers in our state.

**COMMITTEE ON RURAL HEALTH.** This group is constantly meeting with representatives or rural people to discuss rural health measures. Each year they conduct a state-wide rural health conference which is attended by more than 700.

In addition four regional meetings are held annually, at which time farm women are urged to attend. At these they attempt to show how to recognize symptoms of various diseases.

**CHRONIC ILLNESS.** Indiana, we believe, is the only state at present which has a joint committee on Chronic Illness. The Governor of Indiana has seen fit to name the Chairman of the Indiana State Medical Association Committee as chairman of the Governor's Commission on Chronic Illness. A report will be filed with you on this subject.

**COMMITTEE ON CIVIL DEFENSE.** This committee has completed organization plans and has the medical phase of civil defense organized throughout the state and ready for immediate action. Locations for supplies and first aid stations as well as emergency hospital sites, transportation facilities, and routes have been established.

**COMMITTEE ON MATERNAL AND CHILD HEALTH.** This committee works jointly with the Maternal Health Division of the Indiana State Board of Health. A detailed report of this activity will also be filed with you.

**COMMITTEE ON LEGISLATION** has worked hand in hand with the Indiana State Board of Health. We are proud to say that we have supported and worked for the passage of all legislation deemed necessary by our Board of Health.

**COMMITTEE ON MEDICAL CARE INSURANCE.** This group is constantly working with the insurance industry and continually studying medical care insurance in an endeavor to broaden these plans.

**COMMITTEE ON MEDICAL AND NURSING SCHOOL SCHOLARSHIPS.** Our Association in an effort to assist needy young men and women

take up these professions has been granting scholarships for physician and nurse training. In return for this, the graduates agree to practice in communities needing their services, for a period of years, to discharge their debt.

**COMMITTEE ON SCHOOL HEALTH AND PHYSICAL EDUCATION.** This committee conducts annual state-wide conferences for physicians, school administrators, teachers, nurses, etc. Today, in Indianapolis, such a conference is being held. These are followed annually with regional meetings throughout the state. Cooperating with us in this program is the Indiana Department of Public Instruction; Indiana State Board of Health; Indiana State Teachers Association; Indiana High School Athletic Association; Indiana School Board Members Association; City and County School Superintendents Association, and the Indiana State Dental Association.

**COMMITTEE ON CRIPPLED CHILDREN SERVICES.** This committee has cooperated with the official agencies in this field of endeavor. Through arrangements made with our physicians, the medical phase of caring for the crippled children is supplied at practically no cost to the taxpayers of our state. Our physicians are carrying on this

work for a very small honorarium rather than on a fee basis.

In conclusion, let me say, the medical profession of Indiana has been working hard in an effort to encourage people to recognize health, and the benefits to be gained by all from good health practices. We are working closely with all groups, which will permit us to work with them, in an effort to improve continually the health standards of our people and our state. The facts stated herein, while not in as great detail as we would like the opportunity to present them, nevertheless give you some idea of what we are doing in Indiana.

We feel the greatest contribution the government can make to the Health Needs of the Nation, is to encourage those who are working diligently in our voluntary Health programs, rather than to discourage them through some of the insidious propaganda which has been released and which infers the efforts of millions of our people, interested in health, are of no avail. Why not begin a campaign of encouraging more local initiative, and more local voluntary effort? The people will do the job themselves with your encouragement rather than condemnation.

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## EDITORIAL COMMENT ON REPORT . . .

### WE CAN DO IT BEST

In a conference with a presidential committee on the nation's health needs, Indiana State Medical Association president, Dr. William Wright, stated that Indiana should be allowed to solve her medical problems in her own way. Claiming, often without any authority, that local officials cannot adequately provide for the needs of the community's citizens, the Federal government has usurped one after another of the duties and powers of local government. Indiana citizens have vigorously defended their rights to direct their own welfare, education and medical programs. In every case, Indiana has proved that

local officials, backed by interested and thinking citizens of the community, can handle local issues and problems more effectively and more economically than the Federal government. Right now in Indianapolis, the Hospital Development Association aided by local groups is seeking to raise \$12,000,000 for the expansion of the city's hospital facilities. Indiana's spirited defense of her rights to accept local responsibility and to solve her own problems have been reasserted in this renewed attack by Indiana's doctors on Federal intervention and "creeping socialism."

—*Indianapolis Star*



## HEALTH COMMISSION HEARINGS OVER: WORKING ON FINAL REPORT

**I**N THE clean air of candid expression, untainted by any of the emotional irrelevancies that generally accompany discussion of this subject, financing of medical and hospital services received a thorough and competent going over last week before President's Commission on Health Needs. The two-day symposium was the finale of a series of hearings begun last spring. Commission and staff are now hard at work on a final report scheduled to be submitted to White House only ten weeks hence. If present plans are unchanged, it will comprise five volumes: A comparatively short (about 100 pages) summary of findings and recommendations; the report proper, running about 500 pages; an appendix of about same length; a compendium on financing of health services, and an abridged transcript of regional hearings that were conducted by Commission during past summer.

Frequency with which General Eisenhower and Governor Stevenson are referring to economic aspects of health care, in their campaign speeches, is giving this issue a prominence it never enjoyed in past contests for Presidency. Significantly, the former—in his Los Angeles address on Thursday—suggested possibility of Federal assistance in form of loans to voluntary, non-profit health plans. Note: This was main idea of Herter-Flanders bill that got nowhere in Congress a few years ago.

### Much Compressed Into 15 Hours

To summarize within a few pages what was claimed, denied and expounded at the two-day panel discussion is as difficult a task which participants faced—stating their cases in no more than 20 minutes. But your correspondent is going to make the attempt, not only because of uniformly high caliber of witnesses' presentations and the light they shed on a complex, labyrinthine problem but also because of their probable impact on nature of final report which President Truman—and the nation—will receive from this special commission headed by Dr. Paul B. Magnuson. Into a mere 15 hours, spread

over five sittings last Tuesday and Wednesday, was compressed a wealth of information of vital importance to medical education, public health and hospital administration as well as to all concerned with the giving of medical care, and payment therefor.

### Two Spokesmen for AMA Heard

Frank G. Dickinson, chief economist, and George W. Cooley, assistant secretary of Council on Medical Service, were AMA's representatives on panel. Former urged realistic appraisal of what American public spends for medical care and what it gets in return. "They spend," he said, "only 4 per cent for medical care not because they cannot afford to spend more but because they choose to spend 96 per cent of their budgets for items other than medical care." He demonstrated statistically that Americans are receiving appreciably more for their medical care dollar today than in 1935-39.

Cooley's paper traced growth of Blue Cross and Blue Shield, forecasting continued development because "the great majority of the American people do want to stand on their own feet and pay their own way." Major threat to further growth, he said, is Federal interference. "Every organization interested in assisting in the growth of voluntary health insurance has been besieged by propaganda, threatened with Federal legislation and forced to devote both energy and money in defense which might better have been spent in new experiments and improvements," said Cooley. To support his charges, he gave no particulars, yet he was not challenged on this point.

### Insurance and Group Practice Upheld

It is a noteworthy, and perhaps portentous, fact that in spite of conferees' divided opinions and prejudices, none raised objection to principle of health insurance nor was there any insistence from any quarter that the traditional fee-for-service system must be retained as a cornerstone. Too, there was a preponderance of support for group practice. Federal financial

assistance, provided it falls well short of a compulsory insurance plan, stirred considerably less opposition at symposium than had been anticipated.

"Our doctors will be among the first to admit that, at present, . . . too many of our people find the cost of adequate medical care too heavy. . . . Neither the existing private health insurance nor the Administration's proposal for national socialized medicine covers all the people, neither provides adequate protection . . . the usefulness of Federal loans or other aid to local health plans should be explored." This quotation could have come from Commission's panel discussion; it is taken, instead, from Los Angeles speech delivered Thursday by General Eisenhower, whom organized medicine is supporting for President.

### Case for Government

Chief spokesman for national health insurance was I. S. Falk, of Federal Security Agency. Some of his points: Fifty-six per cent of population carries some protection against medical costs but benefits account for less than one-sixth of nation's annual health care bill. Even if voluntary plans continue present rate of growth for next decade, they will still provide only one-fourth of minimum insurance needed. Government coverage would extend coverage to persons excluded from voluntary plans, provide wider scale of benefits and enhance opportunity for aid to medical education, research and hospitals. Supporting arguments were advanced by Michael M. Davis, chairman, Committee for the Nation's Health; Nelson H. Cruikshank, speaking for organized labor; Seymour E. Harris, Harvard economist, and Helen Hall, director of Henry Street Settlement in New York.

State medicine will be fearsome consequence of our failure to adopt government insurance, said Davis. Organized labor is united in its demand, said Cruikshank. Britain's national health service is a success with the people, Harris pointed out. Miss Hall said she is convinced, after talking to English women, that not only is "socialized medicine" an asset to them but it is desired by Americans.

### . . . But on the Other Hand

Strong representations for effectiveness of Blue Shield and Blue Cross came from Dr. Charles G. Hayden, Massachusetts Medical Service; William S. McNary, Michigan Hospital Service; E. A. van Steenwyk, Associated Hospital Service of Philadelphia, and Emerson P. Schmidt, U. S. Chamber of Commerce, as well as AMA's George Cooley. Dr. Hayden charged labor with inconsistency in fighting Taft-Hartley as a slave-labor law while supporting a plan regarded by doctors as slave labor for themselves. Blue Cross growth at rate of 2,500,000 members a year since 1937 is "a phenomenon in public acceptance without parallel in contemporary American life," said McNary. Even the indigent could be cared for by Federal and state aid, with Blue Cross and Blue Shield having participating roles, said van Steenwyk. Schmidt's statement was similar in many respects to Dickinson's, emphasizing that adequate provision for medical expenses is largely a matter of good family budgeting.

Harold M. Groves, University of Wisconsin economist, rejected compulsory insurance but flirted with idea of a compulsory tax on incomes that would go into a national fund for defraying expenses incident to catastrophic illness. "The scheme would be entirely between the government and the taxpayer and the doctors could practice and collect precisely as they do at present," he said.

Voluntary prepayment plans can and should be accelerated in their growth by government, according to Harry Becker, associate director of Commission on Financing of Hospital Care. He proposed Federal subsidies to medically indigent enabling them to pay Blue Cross and Blue Shield premiums, rather than financial support of plans themselves. A stamp plan, involving no means test, might be feasible, Becker said. Washington also could aid voluntary system effectively by allowing Federal workers to pay premiums through payroll deductions. Note: Becker presently on leave from his position as welfare chief of United Auto Workers (CIO) whose president, Walter Reuther, arranged program for panel discussions last week and presided over them.

### Competition Good—Miller

There have been salutary results of competition among commercial insurance carriers and



between them and the non-profit plans, said John H. Miller, vice president of Monarch Life Insurance Co. All have achieved remarkable growth testifying to merits of what they are selling, he asserted. He opposed government subsidies to voluntary plans as a means of providing coverage for indigents on grounds that taxpayers still would have to bear cost.

Presentation by Dr. George Baehr, president of New York's Health Insurance Plan, was a brief in support of comprehensive benefits and group practice along lines followed by HIP. Growth of co-operatives and other consumer-sponsored plans has been retarded at state and local levels by opposition of medical societies, he stated. HIP today has in excess of 360,000 members who receive medical care from 30 groups in various parts of New York City, said Dr. Baehr, although this is only sixth year of operation.

### Education and Hospitals

Dr. Ward Darley, dean of University of Colorado School of Medicine, said financial support of medical schools is inadequate. This is true even though they are now receiving \$45 million more for instructional programs than they did five years ago. Federal help, should it come, must be on a continuing basis and free of bureaucratic control, he said. Dr. Edwin L. Crosby, president, American Hospital Association, argued for payment to hospitals of full costs for services provided; indorsed further physical expansion via Hill-Burton program; appealed for assurance of living wage and security for hospital personnel.

### Public Health and Industry

A dynamic Dr. Vlado Getting, Massachusetts Commissioner of Health, scolded the Truman-Magnuson commission for paying too much attention to cost of sickness and not enough to ways and means of reducing sickness risks. His prepared statement, as were most of the others, was a highly informative exposition of needs and their financing. No. 1 priority should be given to coverage of entire nation with full time local health units, he said. Viewpoints of industry were given by Harold S. Vance, board chairman of Studebaker Corp., and Walter F. Perkins, of Koppers Co., Inc. Former described satisfactory operation of his firm's prepaid health insurance program, a contributory plan run by

the employees. Voluntary methods should be supported but increased public funds for health care seems to be indicated, said Perkins.

### Outlook: More Funds Without Murray-Dingell

Throw everything into hopper—experts' testimony, political promises from campaign hustings, leanings of health commission members as inferred from their remarks and questions, and whatever else may be lying around—and what comes out may be reduced to this: (1) Increased Federal funds for national health will be asked next year, particularly with reference to enlarging output of medical and allied manpower and bolstering local public health facilities; (2) governmental support, both financial and technical, of voluntary prepayment plans—including cooperatives and other independents—seems to be in the cards; (3) prospects of any sort of compulsory medical care scheme are receding.

—Gerald G. Gross, Washington Report.

### "How Sick Is Socialized Medicine?"

This is the title of an excellent article by the noted economist, Melchior Palyi, which appeared in the June 16 issue of the Freeman magazine.

After surveying Britain's national health scheme, Mr. Palyi found that its results were the depressing opposite of its glowing promises.

He found, for example, that less than three years after the program became law in Britain, 553,577 people were on the waiting list for hospital beds; many of the mentally deficient and the helpless aged are left without institutional care to shift for themselves; the costs of governmentalized medicine have almost trebled in four years to more than 10 per cent of the over-inflated national budget; the something-for-nothing Utopia, advertised world-wide, is now in a slow retreat; the people actually pay for what they get "free"; socialism or no socialism, "first class" treatment is open primarily to those who can afford to pay; fewer than 20,000 general practitioners carry the main burden of medical care for more than 45,000,000 people, and there is no progress at all in industrial medicine.

Mr. Palyi's article is out in reprint form. Copies at \$7 a hundred or \$60 a thousand may be obtained from The Freeman, Dept. PB, 240 Madison Ave., New York 16, N. Y.

## News Notes



**T**HE Third Annual Conference on Physicians and Schools, sponsored by the Committee on School Health and Physical Education of the Indiana State Medical Association in co-operation with the Indiana Department of Public Instruction, Indiana State Board of Health, Indiana State Teachers Association, Indiana High School Athletic Association, City and County School Superintendents Association, Indiana School Board Members Association and Indiana State Dental Association was held September 23 in the Marott Hotel, Indianapolis.

The group was welcomed by Dr. G. O. Larson, LaPorte, ISMA committee chairman; heard a talk by Dr. W. W. Bauer, Chicago, director of the Bureau of Education, American Medical Association, and an outline of the work plan of the Health Education and Physical Recreation Division of the Indiana State Board of Health by Robert Yoho, director. Group sessions were held preceding the luncheon when Dr. J. William Wright, president of the host group, introduced guests; Governor Henry F. Schricker spoke informally and Mr. J. C. Rice, superintendent of Elkhart schools, gave a dem-

onstration concerning immunization and health examinations. Group sessions were resumed at 2 o'clock followed by a presentation by Miss Mabel Ruegen, professor of health education in the School of Public Health, University of Michigan, Ann Arbor.

At the time the above photograph was taken Doctor Bauer had left the meeting to visit Dr. Thurman B. Rice, who was ill. Others at the speakers table are:

Floyd Raisor, director of physical education, Muncie public schools; Dr. Thomas A. Hanna, chairman Public School Health committee; Indianapolis Medical Society; Miss Mabel Ruegen, University of Michigan, Ann Arbor; Robert Yoho, Indiana State Board of Health; Paul Boston, superintendent of LaPorte public schools; Governor Schricker; Dr. G. O. Larson, LaPorte, chairman of School Health and Physical Education committee, Indiana State Medical Association; L. V. Phillips, Indiana High School Athletic Association; Joseph C. Rice, superintendent Elkhart public schools; Dr. Charles Howell, Indiana State Board of Health, dental division.



### 32 Doctors Become Members Of Fifty Year Club

Pins and certificates, signifying eligibility for membership in the Fifty Year Club, were mailed out by Indiana State Medical Association headquarters prior to the annual session. Thirty-two Indiana doctors had completed 50 years of continuous practice in the last year. Membership in the Fifty Year Club now totals ----.

New members are: John C. Armington, Anderson; Clarence E. Boyd, West Baden; Carl F. Briggs, Sullivan; Louis M. Friedrich, Hobart; John D. Garrett, Indianapolis; W. D. Gerrish, Clinton; David E. Griffiths, Gary; George R. Hays, Richmond; Fletcher Hodges, Indianapolis; William F. Hughes, Indianapolis; Henry L. Hummons, Indianapolis; John A. Kent, Mulberry; Fred B. Kurtz, Indianapolis; Goethe S. Link, Indianapolis; James B. Maple, Sullivan; Thomas J. Norton, Grammer; Oran A. Province, Franklin; Frank H. Riley, Jamestown; Foss Schenck, Logansport; Russell F. Scott, Kokomo; E. M. Shanklin, Hammond; Earl R. Snyder, Troy; Orville E. Spurgeon, Muncie; Hannah O. Staufft, Elkhart; Walter L. Straughan, Crawfordsville; Fred W. Terflinger, Logansport; Frank L. Tilton, Nashville; Walter C. Van Nuys, New Castle; Orlando C. Wicks, Gary; Charles W. Yarrington, Gary; Albert C. Yoder, Goshen, and Simon J. Young, Kendallville.

### Military Surgeons to Be Briefed on All Directives

Reserve officers of the medical services of the Army, Navy and Air Force will be given complete information on all new directives, including pending Congressional legislation, governing their commissions, active duty requirements and retirement benefits at the 59th annual meeting of the **Association of Military Surgeons** which will be held in the Statler Hotel, Washington, D. C., November 17-19. Point credits for retirement will be given all eligible reserve officers attending the scientific sessions.

**Dr. V. Logan Love**, formerly of Summitville, has joined the staff of the Davis Clinic at Marion.



At the extreme right is Dr. John V. Thompson, Indianapolis, who recently returned from South America where he lectured in English and Spanish before the International Congress of Diseases of the Chest. Other Indiana doctors who were on the South American trip were Dr. James H. Stygall, Indianapolis; Dr. Thomas R. Owens, Muncie, and Dr. J. V. Pace, New Albany.

With Doctor Thompson in the above picture taken in Panama are Drs. William R. Hudson, Detroit, Irving Willner, Knoxville, and Alfred Goldman, Beverly Hills, California.

A competitive examination for appointment of medical officers to the regular corps of the United States Public Health Service will be held on January 6, 7 and 8, 1953. Examinations will be held at a number of places located as centrally as possible in relation to candidates.

Application forms and additional information may be obtained by writing to the Chief, Division of Commissioned Officers, Public Health Service, Federal Security Agency, Washington 25, D. C. Applications must be received by the Division of Commissioned Officers no later than November 25, 1952.

**Dr. William E. Wolf** has opened an office in LaPorte where he will practice medicine. A graduate of the College of Medical Evangelists, Loma Linda, California, Doctor Wolf served his internship at St. Elizabeth Hospital, Lafayette. His medical education was interrupted by three years service in World War II.

### Indiana State League of Nursing Education Planned

A new organization whose objective is to foster the development and improvement of organized nursing services and education for nursing is to be launched on Thursday, November 6, in the War Memorial Building Auditorium, Indianapolis. This new organization will become a branch of the National League for Nursing established in June, 1952.

The program of the Indiana League for Nursing is definitely community centered and through it the nurses, board members and community leaders will meet to pool experience and take action so that people may have the kind, quality, and quantity of nursing care they need.

All Indiana physicians interested in promoting good nursing are invited to attend and become charter members.

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**Joseph E. Palmer**, executive secretary of the Indianapolis Medical Society, and **James A. Waggener**, executive secretary of the Indiana State Medical Association, were on the program for the first Medical Public Relations Institute sponsored by the American Medical Association in Chicago the first week in September. Medical PR representatives attended from 41 states, Hawaii and Canada.

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The town of Ashley is seeking a new physician as the result of the decision of **Dr. Leonard J. Thill** to take a postgraduate course in anesthesia at Michael Reese hospital, Chicago, after which he plans to open an office in Auburn. He has established residence in Auburn.

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**Dr. William R. Noe** has opened an office in Bedford for the general practice of surgery. Doctor Noe, an Army Medical Corps veteran, is a graduate of Indiana University School of Medicine and served an 18 months residency in pathology and a three year residency in surgery at Methodist hospital, Indianapolis.

Seven Indiana surgeons participated in the program of the 38th Clinical Conference of the American College of Surgeons in New York which included a Forum on Fundamental Surgical Problems. They were: **George I. Bernstein, M.D.**, Indianapolis; **Hedwig S. Kuhn, M.D.**, Hammond; **Edwin A. Lawrence, M.D.**, J. H. O. Mertz, M.D., Donald B. Moore, M.D., H. C. Moss, M.D., and **Harris B. Shumacker, Jr., M.D.**, all of Indianapolis.

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### Board of Health Sends Speakers to Cleveland

Three members of the State Board of Health Staff will participate as officers at the 80th annual meeting of the American Public Health Association October 20-24 in Cleveland, Ohio, which will be attended by more than 5,000 public health specialists from all parts of the world.

**Dr. L. E. Burney**, state health commissioner, is a member of the Governing Council and is chairman of the Committee on Professional Education. **Dr. Samuel R. Damon**, director, Bureau of Laboratories, is chairman of the Conference of State and Provincial Public Health Laboratory Directors, and **Robert Yoho**, director, Bureau of Health Education, Records and Statistics, is secretary of the Public Health Education Section.

**Dr. Paul Fugazzotto**, chief serologist, Bureau of Laboratories, has been invited to discuss papers on "Desirable Features of an Intrastate Program for the Evaluation Guidance of Serologic Test Performance" and "Mycolipin (Yeast Lipoid) Antigen in Comparative Serologic Tests for Syphilis."

**Dr. Charles Howell**, assistant director, Dental Division, will speak on "The Effect of Topically Applied Stannous Fluoride on Dental Caries Experience." Mr. Yoho will also participate in a discussion on "Physicians and Schools—Report of the Third National Conference" and in a panel discussion on the demonstration of Kinescopes.



**Dr. Joseph N. Bonner**, who has been a fellow of the Lahey Clinic, Boston, has opened an office for the practice of general surgery in Fort Wayne where he is associated with **Dr. Arnold H. Duemling**. He is a graduate of Georgetown University School of Medicine.

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**Dr. P. H. Schmiedicke** has moved from Williamsport to West Lafayette where he has opened an office for the general practice of medicine. He will continue making daily visits to Pine Village.

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A Fort Wayne general physician and surgeon, **Arthur F. Hoffman, M.D.**, has closed his office and entered Pennsylvania hospital in Philadelphia to study anesthesia. He had practiced in Fort Wayne for the last five years.

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A twelfth full-time doctor has been added to the staff at Longcliff State hospital, Logansport. **Dr. John A. Larson**, superintendent, announces that **Dr. Leonard Lund** has returned after 10 months' army service.

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The Veterans Administration is instituting a **four-month intensive training course in psychiatry and neurology** to fit the needs of physicians without such previous training who are assigned to duty in 22 predominantly psychiatric hospitals. Physicians who have been engaged in general practice may request this training upon applying for a position at one of these hospitals.

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The course will be held at the VA Hospitals in Coatesville, Pennsylvania; Palo Alto, California; and a joint Downey-Hines, Illinois, program near Chicago, Illinois. Physicians will be employed at salaries commensurate with their training and experience (salary range: \$5,500 to \$11,800 per annum) and assigned to the course with travel and per diem for the four-month period.

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Information and applications may be obtained from your nearest VA Hospital or Regional Office, or by writing to the Chief Medical Director, Veterans Administration Central Office, Washington 25, D. C.

### **A.M.A. Rural Health Meeting Dates Set**

The A.M.A. Council on Rural Health has announced that its eighth national conference will be held at the Roanoke Hotel, Roanoke, Va., February 27-28.

The theme of the '53 meeting will be: "Widening the Highway to Health."

Chairman F. S. Crockett, Lafayette, Indiana, said that the program is being built around such subjects as the place of dental care in the rural health program; financing rural medical care, including specific stories of successful accomplishment; how various rural medical care projects have been developed and carried out at the community level, and how similar projects may be put into operation.

Council Secretary Arline Hibbard reports that on Thursday, February 26—the day preceding the formal sessions—members of state rural health committees and committees handling rural health matters will get together at an informal meeting to take up the problem of "Doctor Participation in Community Programs." Doctors at this session will have an opportunity to talk over their problems, exchange experiences and discuss possible activities and programs, putting particular emphasis on community affairs.

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Muncie has a new general practitioner, **Dr. M. Saperstein**, who has just been released from the navy after two years service. He is a graduate of Indiana University School of Medicine.

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**The Fifth Annual Postgraduate Course on Diseases of the Chest** will be presented in the Hotel New Yorker, November 10-14. The course is open to all physicians, but registration will be limited. Application forms may be obtained from: Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

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The interim session of the **American College of Chest Physicians** will be held in Denver on November 30 and December 1.

### To Discuss Radiation Problems At Cincinnati Symposium

A two day symposium on radiation and radiation problems will be given on November 20 and 21, at Cincinnati. The program will include only enough basic physics to make the discussion intelligible and will aim primarily at answering questions posed for the physician by the expanding use of radioisotopes, x-rays, and other radiation producing machines in industry. It should be pointed out that the program will pre-suppose little or no knowledge of radioisotopes and radioactivity.

Topics to be discussed (with demonstrations where practicable) include: Introduction to radiation physics; detection, measurement, and absorption of radiation; biological effects of radiation; personnel protection; and planning for the safe use of radioisotopes. A round table question and answer period will conclude the session.

The symposium will be presented by the Radiological Health Training Section of the Environmental Health Center, Public Health Service, in co-operation with the Division of Occupational Health of the Public Health Service. Sponsoring the symposium are the Health Departments of Kentucky and Ohio, the Indiana State Board of Health, and the Industrial Medical Association. There will be no registration fee.

For further information and registration, write: Chief, Radiological Health Training Section, Environmental Health Center, 1014 Broadway, Cincinnati 2, Ohio.

**Dr. Walter V. Matteucci** has joined **Drs. W. D. Dannacher** and **J. T. Stoops** in the practice of medicine in their new clinic which was opened October 1 in Wabash. Doctor Matteucci, a native of Philadelphia, received his M.D. from Jefferson Medical College, is a veteran and for the last year had been an instructor in medicine at the University of Pennsylvania.

**Capt. Sidney R. Goldstone**, has just completed a two-year tour of duty with the Air Force and is re-establishing his medical and surgical practice in Gary. He has been at MacDill Air Force Base, Florida.

**Arthur G. Loftin**, administrative director of the Indiana Council for Mental Health, and **Dr. Earl W. Mericle**, secretary of the council and chief of staff of the Norways Foundation Hospital, returned to Indianapolis October 18 after a 10-day swing around the state during which they visited all of the mental institutions and hospitals operated by the State of Indiana, under the direction of the Council.

A 1950 graduate of the Indiana University School of Medicine, **Dr. Francis L. Land**, has become associated in Fort Wayne with **Dr. Eugene F. Senseny** in the general practice of medicine and surgery. A native of Anderson, Doctor Land served for five years with the Air Force as an administrative officer and since World War II had served as an instructor in the School of Aviation Medicine at Gunter Air Force base in Alabama.

**Dr. James M. Louisell** has joined the staff of Norman R. Beatty hospital, Westville. A native of Duluth, Doctor Louisell is a graduate of University of Minnesota Medical School and has been in private practice at Bridgeman, Michigan.

### Civil Defense Allocates \$15 Million To States for Supplies

Federal Civil Defense Administration has completed the allocation of \$15 million to the states, which must match the funds with state or local money or forfeit the federal contribution. Money will be spent for medical supplies and equipment, attack warning and other communications, fire-fighting and rescue equipment and for training and public education. Because medical supplies up to now have accounted for about 90% of all CDA expenditures, it is expected that a large percentage of the new allocation also will be used for this purpose. Indiana's share is approximately \$384,000.

Still pending is a decision by FCDA on the breakdown of \$20 million voted by Congress for *federal* stockpiling of medical supplies. The issue is how much to spend on the blood program.



Dr. David B. Templin, Gary physician and president of the Gary Crime commission, is to open an office in Lowell about November 1 and will have Dr. Lloyd Combs, Lowell physician, as an associate. He plans to establish a medical clinic. Before coming to Gary in 1938 to assume the practice of his father, Doctor Templin had been on the Mayo Clinic staff.

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#### Multiple Sclerosis Manuals Ready for Distribution

The National Multiple Sclerosis Society has prepared a manual on physical medicine and rehabilitation for multiple sclerosis patients for distribution to physicians only. From this manual, which received widespread acclaim and distribution, there has arisen a demand for home care program employing physical therapy and rehabilitation techniques. Four such manuals directed to patients have been published. They are: First, for independently ambulatory patients; second, for patients ambulatory with aids—such as canes and crutches; third, for wheel chair patients; and fourth, for the care of bed patients. All these publications are available without cost upon request of the physician, if he will designate which manuals are appropriate to the needs of his patients. Address the National Multiple Sclerosis Society at 270 Park Ave., New York 17, New York.

#### Hoosiers Inducted Into College of Surgeons

Seventeen Indiana doctors were recipients of fellowships from the American College of Surgeons at the close of the annual meeting of that organization of more than 18,000 surgeons on September 26.

Those receiving the F.A.C.S. distinction were: Robert R. Brown, M.D., Terre Haute; Boyd A. Burkhardt, M.D., Tipton; Charles W. Cure, M.D., Indianapolis; Richard M. Davis, M.D., Marion; Donn R. Gossom, M.D., Terre Haute; Paul E. Humphrey, M.D., Terre Haute; Carleton A. Keck, M.D., Fort Wayne; John W. McCallister, M.D., Fort Wayne; H. Allison Miller, M.D., Marion; Lewis E. Morrison, M.D., Indianapolis; Paul F. Muller, M.D., Indianapolis; Frank W. Peyton, M.D., Lafayette; James P. Lowell, M.D., Marion; Herbert F. Sudranski, M.D., Indianapolis; John S. Szynal, M.D., Indianapolis; Charles E. Walters, M.D., Mishawaka; Norbert M. Welch, M.D., Vincennes.

#### *2,640 More Doctors*

The medical population of the United States increased by 2,640 doctors during 1951 according to a report prepared by Dr. Donald G. Anderson, secretary of the American Medical Association's Council on Medical Education and Hospitals. Dr. Anderson lists the number of physicians in the continental U. S. at the end of 1951 as 211,680.



## A.M.A. WASHINGTON OFFICE NEWS

**17,000 Once-Deferred 4F's Now in Service**

The lowered mental standard for military induction, ordered by Congress, is bringing results. Already 17,000 men once classified IV-F for mental reasons are in uniform and approximately the same number are awaiting induction. Of the 114,000 re-examined so far, 33,000 or slightly less than one-third have been found mentally fit for service. Still to be re-examined are 186,000. Congress in June, 1951, directed that the percentile score in the Armed Forces Qualification Test (mental) be lowered from 13 to 10. Re-examinations began the first of this year and are now running at the rate of about 25,000 a month. Congress also ordered that the same physical standards effective in 1945, at the close of World War II, should prevail. The armed forces say, however, that since 1948 physical standards have been no higher than in 1945.

**Management Paying \$1.5 Billion Annually For Life-Health Insurance Benefits**

American employers are paying close to a billion and a half dollars a year for employee *health and life insurance benefits*. This is one of the findings of a U. S. Chamber of Commerce survey of "fringe benefits," or labor costs not shown on the actual payroll.

The survey, taking in 736 companies, is the third annual study by the Chamber in this field. It groups together "life insurance premiums, death benefits, sickness, accident and medical-care insurance premiums, hospitalization insurance, etc.," and establishes that they cost management an amount equal to 1.4% of its total payroll. (Because many companies purchase combined life-health insurance, no breakdown between the two is possible.)

An indication of the rapid increase in employer-financed life-health insurance in the last four years is the fact that *the average company now pays exactly as much for these particular items as for Old Age and Survivors Insurance (U. S. Social Security).*

In addition to death and health insurance, fringe benefits include such things as pensions,

workmen's compensation costs, terminal pay, profit-sharing plans and payment for time not worked (holidays, lunch hours, etc.). Their total cost to management, the Chamber found, equalled 18.7% of payroll. In dollars, the Chamber estimates that American industry annually pays something less than 25 billion for these benefits. The report is available at U. S. Chamber of Commerce, Washington, D. C., at \$1 per single copy, or 50 cents each for 50 or more.

**Polio Incidence this Year Now Certain to Surpass Recent Record Year of 1949.** U. S. Public Health Service reports there is "little doubt" now that incidence of poliomyelitis this year will surpass that of 1949, the year generally considered to be a record. For the week ending September 20, cases totaled 34,291 or 4,038 more than the same period in 1949. However, Dr. C. C. Dauer, medical consultant of PHS National Office of Vital Statistics, states that **contrary to the popular conception, the year 1916 was the worst from the standpoint of mortality.** "It is a question," he states, "of how you define the word 'worst.'"

In 1916, with only 28 states reporting, the total of paralytic cases was 29,000, with 7,200 deaths. At that time, Dr. Dauer points out, non-paralytic cases were not reported and 20 states did not even report mortality figures to PHS. In 1949, on the other hand, with 48 states reporting, the total cases were 42,000 and deaths 2,700.

Dr. Dauer commented: "If the ratio of deaths to total cases in 1916 had been followed in 1949, there should have been 100,000 cases in the latter year. **Nothing has ever approached 1916.**" This is the fifth straight week of high incidence with no indication the peak has yet been reached. The peak occurred as late as the first week in October in 1930 and 1936.

**Permanent 'Rusk Committee' Proposed**

The Health Resources Advisory Committee (Rusk Committee) has recommended that it (or a similar group) be continued on a permanent basis. Its summary report says: "It has become increasingly apparent . . . that some mechanism similar to the Committee should be continued not only during this period of mobilization but as a permanent statute of the federal government.



The Committee believes it is vital that . . . at a sufficiently high organizational level to make its work effective, there must be a coordinating body in the health fields if full utilization for both civilian and military needs is to be made of the health potentials of our nation."

The Committee, organized in 1950, now has three roles, (a) advising Office of Defense Mobilization on all health matters, (b) functioning as the National Advisory Committee to Selective Service, and (c) advising Defense Department on call up of medical reserves by balancing civilian against military needs for physicians and other personnel in the health fields.

The Committee commended the Armed Services for providing the best military medical care in history, while at the same time reducing the physician ratio from the World War II peak of six per 1,000 troops to the current 3.7. This means, the Committee explains, that 5,000 physicians who might be in military service have remained in civilian practice. The Defense Department saving resulting from the lower ratio was estimated at 40-50 million dollars.

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**No Decision Yet on Release of VA Management Study.** Although the final volume of the comprehensive survey of Veterans Administration has been completed for more than 3 months, no decision has yet been made on when or how to release the report. Booz, Allen & Hamilton, Chicago management engineers, undertook the investigation in January, 1951. They completed the task last June 24, including preparation of a summary, condensing the mass of findings and recommendations into one volume. Officials of the U. S. Budget Bureau as well as Veterans Administration currently are studying the report. Decision on release of the report will be made by VA Administrator Carl R. Gray, Jr., or President Truman.

VA has another acute problem at present. It is attempting to absorb its \$31 million budget cut without laying off medical personnel—physicians, nurses and dentists. To get expenses of the Medical Department under the limitation set by Congress, about 3,000 hospital beds are being closed out and 6,000 positions eliminated. However, all professional personnel, according to VA, are being offered assignments elsewhere.

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#### **More Medical-Social Developments Reported at ILO Headquarters**

Two more developments of some medical interest are reported from *International Labor Or-*

*ganization's headquarters* in Geneva. An ILO survey, with special reference to the chemical industry, concluded that American physicians generally oppose frequent rotation of night workers, while European experts favor more frequent change. Americans were said to feel that rotated night workers were particularly subject to gastric disorders, possibly caused by necessity of repeated adaptation to new hours. The report was limited to discussion and fact-finding and is not proposed as the basis for a treaty. An ILO convention (treaty) becoming effective next January 21 specifies that a minimum of 30 square feet of floor area be provided for each crewman in ships of 3,000 tons or more. The agreement, drawn up in 1946 and revised in 1949, became effective upon ratification by the twenty-third country, Portugal. The convention has not been approved as a treaty by the U. S. Senate, although it was submitted by the President during the 81st Congress.

(Two reports on how ILO operates in medical and social fields appear in the *Journal of the American Medical Association* for August 23, 1952, (Vol. 149, No. 17). *Medical Care and the International Social Security Treaty* was written by Leonard J. Calhoun, Washington attorney and social security expert, who was alternate employer member for the American delegation to this year's ILO conference. The other, *The International Labor Organization—Its History, Purpose and Plans*, was prepared in the office of AMA's Committee on Legislation.)

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**Defense Mobilizer Cites Progress in Civil Defense Medical Program.** In his quarterly report to the President, the director of the Office of Defense Mobilization states that the "most encouraging progress" in the entire civil defense program is in the field of medicine. Particular progress was noted in procuring first aid station supplies, reserves of medical and surgical supplies, emergency blood donor and transfusion equipment, blood plasma and plasma expanders. However, the procurement picture is not as bright for equipment for improvised hospitals and supplies for biological radiological warfare defense, ODM Director Henry Fowler informed the President.

## Deaths

**James L. DeNaut, M.D.**, 82, died on September 4 in Knox after an illness of several months duration. In 1947 Doctor DeNaut celebrated 50 years of medical service to the Starke county community. He was a member of the Fifty Year Club of the Indiana State Medical Association. He had been in semi-retirement. A French-Canadian, Doctor DeNaut came to the United States and entered Rush Medical School in Chicago when 16 years of age. Following graduation there in 1896, he served one year at Mark Medical Center in Ohio, then established his practice in Hamlet. During his 56 years in practice he had served as county coroner and county health officer several times. He was a leader in the drive to establish Starke Memorial hospital.

**Stanley B. Gordin, M.D.**, 47, died suddenly September 1 in his Fayette county home. A 1930 graduate of the Indiana University School of Medicine, he had practiced for many years in Alquina with his father, Dr. Stanton E. Gordin, who died earlier this year. Recently Doctor Gordin established offices in Connersville. He was a member of the Fayette-Franklin Medical Society and of the Indiana and American Medical Associations.

**James R. King, M.D.**, Silver Lake, died in Murphy Medical Center, Warsaw, September 15. He had been ill for more than two years. Doctor King, who was 83 years old, was graduated from Baltimore University School of Medicine in 1893. He had practiced in Roanoke, Macy and Silver Lake for the last

59 years. Doctor King was a member of Kosciusko County Medical Society, a Fifty Year Club member of the Indiana State Medical Association and a member of the American Medical Association.

**Dr. Miles F. Porter, Jr., M.D.**, 65, died in his Fort Wayne home September 4 as the result of illness which had restricted his practice since last January. He was the fourth generation of physicians and surgeons in his family, all of whom practiced in the Fort Wayne area. A graduate of Harvard Medical School in 1911, Doctor Porter established his practice in Fort Wayne and had been in general practice there since. He served in the Army Medical Corps during World War I. Doctor Porter had been both secretary and president of the Fort Wayne and the 12th District Medical Societies and also held a fellowship in the American Medical Association throughout his career.

**Robert C. Rogers, M.D.**, Bloomington physician for 57 years, died October 6. He had fractured a hip early in August. Born in 1870, Doctor Rogers received his degree in medicine from the University of Louisville School of Medicine. With the exception of several years service as a surgeon during the Spanish-American war and World War I, he had practiced in Monroe county where he had been county coroner, county health officer and served on the Bloomington city council at various times. He was a senior member of the Indiana State Medical Association, having received his Fifty Year Club pin in 1947.



## Society Reports

### INDIANA STATE MEDICAL ASSOCIATION

#### EXECUTIVE COMMITTEE

October 5, 1952

Roll call showed the following present: C. J. Clark, M.D. chairman; W. L. Portteus, M.D.; J. William Wright, M.D.; Paul D. Crimm, M.D.; Wemple Dodds, M.D.; Roy V. Myers, M.D.

Frank B. Ramsey, M.D., editor of *THE JOURNAL*; Byron Emswiler, attorney; James A. Waggener, executive secretary, and Robert J. Amick, field secretary.

#### Membership Matters

##### (1) Report on membership:

Number of members October 3, 1952...3,702\*

Number of members October 3, 1951...3,602

Gain over last year..... 100

\* Includes 76 in military service (gratis)

112—\$10.00 members (residents and interns)

248—senior members

1—honorary member

62—members, dues remitted by Council

(2) Letter from St. Joseph County Medical Society was read and it was determined the subscription to *THE JOURNAL* should be stopped at the end of this year.

#### Headquarters Office

New membership card was approved by consent.

#### 1952 Annual Session, Indianapolis, October 28, 29 and 30, 1952

Upon motion of Drs. Portteus and Wright, Dr. Crimm and the executive secretary are to meet with representatives of the National Exhibitors Association during the annual session.

The plan for policing the exhibits by a committee of exhibitors was approved by consent.

Two bills from the Woman's Auxiliary were approved for payment upon motion of Drs. Wright and Crimm.

A slip to be given to all doctors registering at the annual session, calling attention to the exhibits, was approved upon motion of Drs. Crimm and Myers.

Rental of typewriters from the Central Typewriter Exchange in Chicago for use in making the badges at the annual session was approved upon motion of Drs. Portteus and Clark.

#### Legislative Matters

##### National:

Dr. Wright reported on his appearance before the President's Commission on Health Needs of the Nation at the hearing held in Detroit, Sep-

tember 23, and stated that the Indiana testimony received favorable comment.

A letter from Dr. Frank E. Wilson, director of the Washington Office of the American Medical Association, was read, calling attention to the regional legislative conference in Chicago on November 7 and asking for representation of the Indiana State Medical Association. By consent, it was agreed that Dr. Wright, Dr. Crimm, Dr. Ochsner, Dr. Mericle, and the executive secretary should attend.

##### Local:

The resignation of Dr. Don Wood as chairman of the Committee on Public Policy and Legislation was read and accepted.

Dr. Wright reported upon his recent meeting with officers of the Chamber of Commerce regarding the proposed bill concerning the change in the Workmen's Compensation Act. It was the feeling of the committee that the Association should remain neutral in this controversy if at all possible.

#### Organization Matters

Request of Dr. Thurman B. Rice to reprint certain parts of "One Hundred Years of Indiana Medicine" was granted, on motion of Drs. Wright and Portteus, with the suggestion that credit be given the source.

The request of the Indiana Academy of General Practice to use the mailing list for addressing invitations to its April, 1953, meeting was approved, on motion of Drs. Wright and Portteus.

The communication from the Indiana Academy of General Practice requesting the association to recommend to their membership that November 4 be declared a medical holiday was considered, and a letter is to be sent to the presidents and secretaries of county medical societies recommending that this be done, except for the handling of emergencies. This was approved on motion of Drs. Portteus and Wright.

Upon motion of Drs. Wright and Portteus, it is to be recommended that the Council take official action declaring November 4 a medical holiday, with the exception of medical emergencies.

A \$10.00 membership in the Indiana State Conference on Social Work was approved, on motion of Drs. Wright and Dodds, with Dr. Crimm dissenting.

Payment of \$75.00 in dues to the Conference of Presidents was approved upon motion of Drs. Wright and Dodds.

The request of Purdue University for approval of a proposed health plan for the 4-H Clubs was laid over until the next meeting of the committee

in order that the members might have an opportunity to study the proposal, upon motion of Drs. Wright and Dodds:

By consent it was agreed that Drs. Wright and Crimm should cooperate in naming a committee to consider a fee schedule for the Vocational Rehabilitation Program.

The secretary reported the receipt of material from the Indiana Department of Public Welfare and also distributed copies of a proposed change in regulations concerning the handling of death certificates.

#### The Journal

*Report on advertising* was accepted by consent:

Total, September, 1951.....	\$2,266.78
Total, September, 1952.....	\$2,063.18

#### Future Meetings

Dr. Paul D. Crimm is to represent the Indiana State Medical Association at the annual dinner meeting of the Kentucky State Medical Association, October 9, 1952.

#### New Business

On motion of Drs. Crimm and Dodds, a letter from Mr. Stump concerning the article appearing in the Illinois State Medical Society News-Letter on the establishment of a system for investigating improper testimony by physicians in court hearings was referred to the Board of Appeals on Patient-Physician Relations.

There being no further business, the committee adjourned to meet again at 3:00 p.m. on Monday, October 27, 1952, at the Columbia Club, Indianapolis.

### COUNCILOR DISTRICT MEETING

#### ELEVENTH DISTRICT

Ninety persons attended the ninetieth semi-annual meeting of the Eleventh Indiana Councilor District Medical Association at the Logansport State hospital September 17. Floyd Kerlin, Indianapolis, was the speaker, discussing "The Doctor's Income Tax." Throughout the afternoon doctors from Cass, Carroll, Howard, Grant, Miami, Wabash and Huntington counties attended a business and scientific program. Dr. Richard Good, president, Kokomo, conducted the business meeting which was followed by a psychosurgical clinic arranged by Dr. John Larson, superintendent at Longcliff State hospital; a discussion of thrombosis and its treatment by Dr. Cris Segard, New York; an outline of the new classification of mental disorders by Dr. George Morrow, assistant Longcliff superintendent. A symposium on neurosurgery concluded the scientific program. Participants were Drs. E. Rogers Smith, John Hetherington, John Larson, E. B. Jewell and Foss Schenk.

Doctor Jewell was general chairman of the committee on arrangements for the district meet-

ing. Mrs. B. R. Hall served as chairman of the tea and program planned for the auxiliary members.

Dr. J. William Wright, Indianapolis, president of the Indiana State Medical Association and James A. Waggener, executive secretary, were among the special guests.

### LOCAL SOCIETY REPORTS

Dr. Harold D. Caylor, Bluffton, was the speaker at the September 16 meeting of the **Wells County Medical Society**. He gave a report on the meeting of the International College of Surgeons. The county meeting was held in the Caylor-Nickel Clinic building.

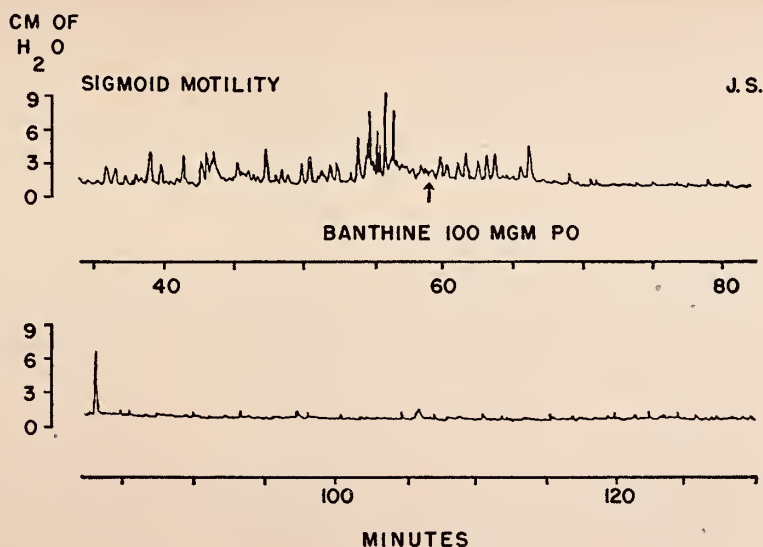
**Camp Atterbury Medical Society** met September 18 at which time medical officers heard Dr. L. W. Freeman, associate professor of surgery and director of the surgical experimental laboratories at the Indiana University Medical Center, present a paper on "The Treatment of Acute Injuries of the Spinal Cord and Some Experimental Observations on Spinal Cord Regeneration."

**Wabash County Medical Society** members met October 8 for a 6:30 o'clock dinner meeting in the Honeywell Memorial center in Wabash. Dr. John W. McAllister, Fort Wayne, gave a paper on "Emergency Chest Surgery." The 12 members present formulated plans concerning the November election, discussing candidates favorable to the medical profession and accordingly opposed to socialized medicine. The next meeting will be held November 12.

Six members and one guest attended a business meeting of the **Orange County Medical Society** held in the West Baden Springs Hotel on September 2.

Dr. J. E. Arata, Fort Wayne, discussed "Early Diagnosis of Pulmonary Lesions" before the ten members and five doctors and dentists who were guests of the **Whitley County Medical Society** on September 9. The meeting was held in Whitley County Memorial hospital.





The effect of 100 mg. of Banthine on sigmoid motility. The contractions did not return during the experimental period.<sup>1</sup>

## In Intestinal Hypermotility—Banthine®

*"...has a prolonged inhibitory effect on human gastrointestinal motility. . .*

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It has also been observed that definite retardation in gastrointestinal transit time in individuals with hypermotility was attributable to the therapeutic effect of Banthine.<sup>2</sup>

**BANTHINE®** Bromide (brand of methantheline bromide)—a true anticholinergic—is available for oral and parenteral use.



1. Kern, F., Jr.; Almy, T. P., and Stolk, N. J.: Effects of Certain Antispasmodic Drugs on the Intact Human Colon, with Special Reference to Banthine ( $\beta$ -Diethylaminoethyl Xanthene-9-Carboxylate Methobromide), *Am. J. Med.* 11:67 (July) 1951.

2. Lepore, M. J.; Golden, R., and Flood, C. A.: Oral Banthine, an Effective Depressor of Gastrointestinal Motility, *Gastroenterology* 17:551 (April) 1951.

RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

*Patronize Your Advertisers*

Noble County Medical Society held its October 7 meeting in the offices of Dr. H. O. Williams and Dr. F. W. Messer where they participated in a telephone seminar. It was agreed by the seven members present that the seminars were of valuable assistance to the doctors and they recommended they be continued for another year. The next meeting was scheduled for November 4 at 8 p.m. in the same location.

Shelby County Medical Society members met in the W. S. Major hospital, Shelbyville on September 10 when they heard a report of the local Cancer Society committee relative to the purchase of equipment for the Major Hospital; held a final discussion on the proposed emergency call system and heard a wire recording on "Cesarean Section." Sixteen members attended.

LaPorte County Medical Society members heard a paper on "Office Gynecology" by Dr. Fred O. Priest at their September 18 dinner meeting in Peacock Inn, Rolling Prairie. Forty-three doctors attended.

The Wells County Medical Society held its sixth annual Fall Clinical Conference, Wednesday, October 8 at the Bluffton Country Club. Sixty-one physicians attended the program.

The speakers in order of their appearance on the program were as follows: Howard P. Doub, M.D., F.A.C.R., radiologist-in-chief, Henry Ford Hospital, Detroit, "Roentgen Studies of Chronic Arthritis of the Spine"; George Andros, M.D., assistant professor of obstetrics and gynecology, Chicago University Medical School, "Prevention and Treatment of Prolonged Labor"; Matthew Winters, M.D., F.A.A.P., professor of pediatrics, Indiana University School of Medicine, Indianapolis, "Recent Advances in Pediatrics"; Robert E. L. Berry, M.D., F.A.C.S., associate professor of surgery, University of Michigan School of Medicine, Ann Arbor, "The Management of the Severely Burned Patient"; Leslie W. Freeman, M.D., Department of Surgery, Indiana University School of Medicine, Indianapolis, "Practical Considerations in the Treatment of Patients Suffering from Acute Injury to the Spinal Cord or Spinal Nerve Roots".

Dinner was served and an address of welcome was given by Dr. Thomas O. Dorrance, president of the Wells County Medical Society. The President of the State Medical Society, Dr. J. William Wright, spoke briefly regarding "Your State Society". The final speaker of the evening was Jerome Conn, M.D., F.A.C.P., professor of internal medicine, University of Michigan, School of Medicine, Ann Arbor, "Diagnosis and Management of Spontaneous Hypoglycemia".

Dr. J. L. Sims, assistant professor of medicine at the University of Wisconsin spoke on "Liver Test Functions" to 44 members and guests of the Elkhart County Medical Society in the Hotel Elkhart on September 4. Elkhart county doctors joined Auxiliary members for a chicken barbecue at Studebaker park on September 17.

Members of the Grant County Medical Society acted as hosts to a group of Fifth Congressional district doctors and their wives at an early fall picnic dinner at the Marion Veterans hospital. Their speaker was Congressman John V. Beamer, Wabash, who discussed the dangers of socialism. He outlined the devious methods used to include socialized medicine features in bills by means of legislative trickery.

## INDIANA STATE BOARD OF HEALTH

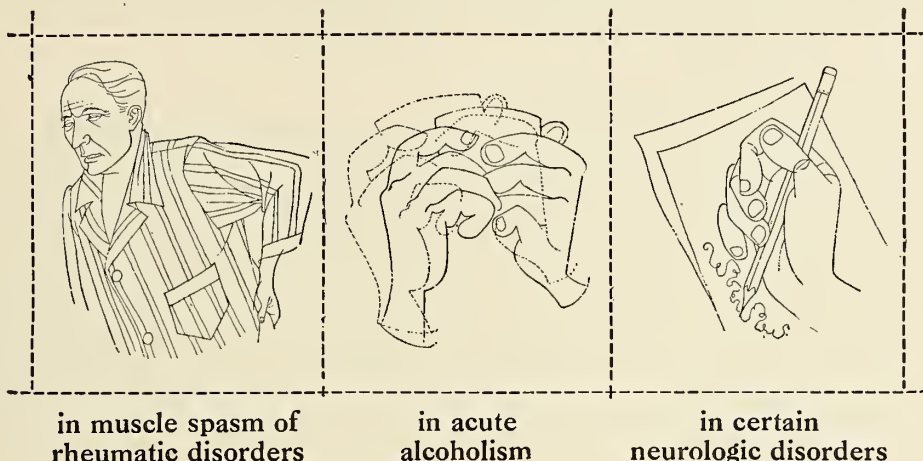
### Division of Communicable Disease Control

#### MONTHLY REPORT—AUGUST 1952

Disease	Aug. 1952	July 1952	June 1952	Aug. 1951	Aug. 1950
Brucellosis	2	0	0	1	4
Chickenpox	4	35	143	5	8
Diarrhea	5	0	5		
Diphtheria	2	0	2	2	9
Dysentery,					
Bacillary	3	2	0	0	0
Virus	14	0	0	0	0
Encephalitis	5	4	6	0	2
Food infection	3	2	2	3	0
Influenza	4	2	3	33	1
Infectious hepatitis	12	11	34	6	0
Malaria	7	3	6	0	0
Measles	18	303	538	21	17
Meningitis					
Unclassified	7	12	6	5	1
Meningococcal	1	4	4	0	0
Pneumococcal	1	0	0	0	0
Mumps	21	45	158	24	9
Paratyphoid	5	0	0	0	0
Pneumonia	14	32	34	7	20
Polio myelitis	317	63	19	81	88
Rabies in animals	8	17	20	32	25
Rocky Mt.					
Spotted fever	1	0	0	0	1
Rubella	1	6	58	0	3
Streptococcal infection	16	67	46	12	20
Tetanus	2	2	2	2	1
Tularemia	1	0	0	0	4
Typhoid fever	8	3	3	4	16
Vincent's angina	4	1	0	3	0
Whooping cough	30	34	30	96	90



# new uniform oral dosage



The new, uniform oral dose for adults is 1-3 grams. This may be repeated 3-5 times per day.

The first dose prescribed should be at the lower end of the recommended dosage range (*an occasional patient may complain of side effects when large doses are given at the start of Tolserol therapy*). Subsequent doses may be adjusted to the needs of the individual patient. Whenever possible, Tolserol should be given after meals. When Tolserol is given between meals, it is desirable that the patient first drink  $\frac{1}{3}$  glass of milk or fruit juice.

## Tolserol

*Squibb Mephenesin*

*Tablets, 0.5 Gm. and 0.25 Gm., bottles of 100; Capsules, 0.25 Gm., bottles of 100; Elixir, 0.1 Gm. per cc., pint bottles; Intravenous Solution, 20 mg. per cc., 50 cc. and 100 cc. ampuls.*

# Books

## BOOK REVIEWS

**ANATOMY IN SURGERY.** By Philip Thorek, M.D., University of Illinois College of Medicine. 970 pages, with 720 illustrations, 211 in color, drawn by Carl T. Linden, instructor in medical illustration, University of Illinois College of Medicine. Price \$22.50. J. B. Lippincott Company, East Washington Square, Philadelphia, 1951.

As stated by Dr. Cole in his foreword, Doctor Thorek "has deviated considerably from the usual plan and has presented the material with a stronger surgical viewpoint." There has been some tendency in recent years to emphasize surgical physiology at the expense of anatomy. Both are essential to the training of a surgeon and this volume should be helpful indeed both to the young man in training and to the older surgeon who needs refreshing along anatomical lines.

A teaching book—especially one on a subject essentially structural in nature—depends in great degree upon the accuracy and clarity of its illustrations, and in this respect Thorek's *Anatomy* rates high. Color is used in 211, an aid which is invaluable for ease of comprehension where structures interlace. An excellent feature is the large letters used in labeling.

The book is systematically arranged in ten sections, e.g., head, neck, thorax, abdomen, etc., each section being subdivided. A sample of the system used: Under Section 8, Superior Extremity comes the Arm (Brachial Region)—Surface anatomy, fascia, muscles, nerves, surgical considerations of the radial nerve, arteries and veins, surgical considerations of the brachial artery, humerus, surgical considerations, fractures, operations on the shaft of the humerus.

At the beginning of the book is a "List of Basic References" which in itself is a valuable reminder of the classic and standard works on anatomy. Representative operations are described for each region covered. While this is not a treatise on operative surgery, such descriptions of technique serve to emphasize the relationship between surgical approach and the anatomy involved in establishing the technique itself. The index seems to be well organized and adequate.

**MANAGEMENT OF CELIAC DISEASE.** By Sidney V. Haas, M.D., New York Polyclinic Medical School; and Merrill Haas, M.D. 188 pages, with 12 illustrations. Price \$5.00. J. B. Lippincott Company, E. Washington Square, Philadelphia, Pa. 1951.

This book is relatively short. One wonders, knowing the large amount of research and writing done on Celiac Disease, how this book could be very complete. The authors have used an old, but useful device by presenting all of the pros and cons in a short and concise form and should one be more interested, there is a very extensive bibliography consisting of some 668 references.

Using the above method, the authors cover the history, definition, incidence, etiology, clinical symptoms, pathology, roentgenographic evidence, a review of digestion and absorption, the action of digestive juices, endocrine system, nervous system, allergy, diagnosis, treatment and prognosis of Celiac disease. The authors then give their present concept of Celiac disease and finally their etiologic hypothesis, based on observed clinical findings in treating over six hundred patients, rather than from laboratory findings.

In a nutshell, the authors feel that the diarrhea

Books received are acknowledged in this column, and such acknowledgment must be regarded as a sufficient return for the courtesy of the sender. Selections will be made for more extensive review in the interests of our readers and as space permits. Books listed in this department are not available for lending. Any information concerning them will be supplied on request.

## BOOKS RECEIVED

**ESSENTIALS OF DERMATOLOGY.** By Norman Tobias, M.D., associate clinical professor of dermatology, St. Louis University. 596 pages, profusely illustrated. Price \$6.00. J. B. Lippincott Company, E. Washington Sq., Philadelphia, Pa. 1952.

**CORRELATIVE NEUROANATOMY AND FUNCTIONAL NEUROLOGY.** By Joseph J. McDonald, M.D. professor of surgery, Columbia University, and Joseph G. Chusid, M.D., attending neurologist, St. Vincent's hospital, New York. 263 page manual, illustrated. Price \$4.00. Lange Medical Publications, University Medical Publishers, P. O. Box 1215, Los Altos, California. 1952.

**PARDON MY SNEEZE.** By Milton Millman, M.D., fellow American Academy of Allergists. 217 illustrated pages. Frye & Smith, Ltd., San Diego, California. 1952.

**BRAIN SURGEON.** By William Sharpe, M.D., director of neurosurgery, Manhattan General hospital, New York. 271-page autobiography. Price \$3.75. The Viking Press, Inc., 18 East 48th Street, New York 17, N. Y. 1952.

**RESEARCH IN ENDOCRINOLOGY.** By August A. Werner, M.D., assistant professor of internal medicine, St. Louis University School of Medicine. 285 illustrated pages. Dr. August A. Werner, 403 Humboldt Building, St. Louis 3, Missouri. 1952.

**GYNECOLOGIC AND OBSTETRIC PATHOLOGY.** By Emil Novak, M.D., assistant professor of gynecology, The Johns Hopkins Medical School. Third edition, 595 pages with 630 illustrations. Price \$10.00. W. B. Saunders Company, West Washington Square, Philadelphia 5, Pa. 1952.

of Celiac disease is probably caused by an anthroquinone irritant produced by an intestinal microorganism on the polysaccharide substrate in the unrestricted diet. This microorganism has not been isolated, but by strict dietary regulation the diarrhea can be controlled.

The authors have mentioned the B-complex vitamins but not folic acid or B<sub>12</sub> specifically, in relation to Celiac disease, nor has there been much in the recent literature. That which has been published does not show the promise in Celiac disease per se that it does in non-tropical sprue. Neither has ACTH nor Cortisone been reported as beneficial.

The authors point out that there is no intolerance to fat. The patients are unable to tolerate the polysaccharides except those found in pure fruits, vegetables and protein milk. Then when treated by means of a "carbohydrate specific diet" without exception, these children grow and develop normally and later are able to return to an unlimited diet.

The senior author, Dr. S. V. Haas, has been intensely interested in this disease for more than fifty years, and has contributed much to the care and understanding of the patient. In this book, as in his work, he has given much of himself.

L. G. M.



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# *Opinions From Here and There*

Prepared for your information by the Committee on Public Policy and  
Legislation of the Indiana State Medical Association

The People Have Spoken as has been proven by the large number of votes cast in the election, November 4. They spoke loudly against socialistic schemes, corruption, high taxes, and war. Our foundations have been cracked during the past twenty years, the roof has been leaking and many windows are missing in our system of government.

The great task of hurrying these needed repairs now faces the Republican party, these repairs must be made before a world disturbance shakes the house and brings it down in ruins.

While we have spoken with our ballots we must remember that merely casting a vote does not complete our responsibility as far as government is concerned. We must remain interested in all that happens, we must let our representatives in congress know how we feel on important issues, we must express our appreciation when wise decisions are made.

\* \* \*

AMA regional legislative conferences are eye openers to those who have been privileged to attend. It is regrettable that every member of the medical profession is not fully informed on how our parent organization is working in our interest every day throughout the year.

Representatives from midwest states met in Chicago November 7, with the director and some of the staff of the Washington office of the AMA for an explanation of the workings of the office and the relationship of the office to the Congress and the members. It should become a regular practice for the secretary of the component county medical societies to read in full the report of the Washington office before the society at every meeting.

Financially, it is impossible for the Washington office to send their publication "Capitol Clinic" to every member of the AMA. But every county society officer is entitled to a copy. If a few minutes could be taken at every Society meeting for a reading of these reports, we believe every member would have a much better explanation of what is going on and what some of your AMA dues is spent for.

\* \* \*

As the administration of government changes it is time we reviewed some of the opinions of our new President. Here is a brief digest of how President-elect Eisenhower and the Republican party stand on major medical issues.

Specifically as well as generally, the Republican administration should be found in fairly

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close agreement with American Medical Association on several major issues due to reappear before Congress in the next two years—issues on which the Association and the Roosevelt and Truman administrations were at odds continuously. The Republican platform and pre-election statements by General Eisenhower suggest that the following situation may be expected:

**Socialized Medicine:** General Eisenhower has stated repeatedly that he is opposed to national compulsory health insurance or socialization in any other form. On this he is supported all the way by the Republican party's platform. In contrast President Truman consistently advocated compulsory health insurance. This does not mean the end of the issue, but a safe assumption is that it will lie dormant for the next two years.

**Aid to Medical Education:** General Eisenhower is determined that every effort be made to support medical education without resort to federal financial assistance; long before his nomination he was active in efforts to raise private funds to assist medical schools. AMA is in substantial agreement with his ideas on this subject; it believes states and private sources should accept responsibility for supporting the schools, with federal funds used only for "one time" construction and equipment grants where the need is clearly demonstrated.

**Pension plans for self-employed:** The General has indorsed extension of tax relief to self-employed persons to help them establish pension funds, a proposal which has the active support

of AMA and a number of other national associations. He has stated: "There are over 10,000,000 workers who cannot take advantage of tax relief provisions now offered to corporations and their employees . . . I think something ought to be done to help these people to help themselves by allowing a reasonable tax reduction for money put aside by them for their own savings."

**Veterans' Medical Care:** The General promised a "firm assessment" of the Veterans Administration's medical care program, stating that charges of deterioration were "seriously disturbing" to him. He added: "I shall exert every appropriate effort to achieve a Veterans Administration program for proper maintenance of its many services and benefits, including the best medical care and facilities available. These matters . . . will be of primary concern to me."

The Republicans have pledged continued support of scientific research, the "encouragement of improved methods of assuring health protection", and the maintenance of a program to stimulate development of adequate hospital services. On social security, Gen. Eisenhower stated: "We must improve it and extend it. . . . Security for old age, unemployment insurance, care for dependent children and widows . . . are moral obligations. But they also are a sound investment. . . ."

**Pentagon conference starts discussions on Doctor Draft Law extension—**Defense Department officials, with the assistance of representatives from other federal departments and

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professional associations, have started work on problems of the physician-dentist-veterinarian draft, preparatory to asking for an extension and amendment of Public Law 779, scheduled to expire next June 30.

Defense Department's Armed Forces Medical Policy Council sponsored the first discussion meeting, attended by spokesmen for dentists, veterinarians, hospitals, and medical schools, as well as the American Medical Association. Represented also were the Armed Forces, Defense Department's manpower division, Selective Service and the Rusk committee.

At the first meeting, held in the Pentagon, a Defense Department spokesman gave this outline of the problem:

1. Medical Priorities I and II will be exhausted shortly, and future requirements will have to be met from Priorities III and IV. Questionnaires are now being sent to a number of physicians in Priority III.
2. There aren't enough young men in Priority III to meet military requirements for long; unless the younger men in Priority IV are made available by a change in the law, the services will be offered too many of colonel and major age and experience, not enough for the captain and lieutenant commissions. Dislocating physicians of 15 to 20 years experience from their civilian practice will create additional problems.
3. The age and experience level of Priority IV men make many of them more acceptable, but it is possible that a high percentage already have had two or more years of active

military duty; besides, these men can't be called until Priority III has been used up.

4. The professional manpower shortage will continue until 1958, when enough non-veterans, currently deferred from the regular draft to complete their medical training, will be available to meet most military requirements.

No conclusions were reached at the first meeting, and association representatives were not asked to pledge support for an extension of PL 779 at this time.

\* \* \*

**Why should we say, as we always do, that free enterprise provides an incentive for profit and that the profit motive creates jobs and prosperity? All that, of course, is true. But it is also true that free enterprise does much more than that in terms of human values. Right now, American Industry, the child of free enterprise, is serving as the bulwark of peace, which is highest of human values and without which freedom cannot exist.**

\* \* \*

**Compulsory insurance is a verdict for state socialism—any suggestion for state insurance or compulsory insurance is a verdict for State Socialism and one against private enterprise.**

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**"Hidden payroll" benefits placed at \$25 billion—according to an estimate of the U. S. Chamber of Commerce. Their report states that**

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businessmen pay their employees nearly \$25 billion a year in "hidden payroll" benefits.

The estimate was based on a survey of 736 companies which disclosed that companies paid out an average of \$644 per employee last year in fringe benefits. This marked a 66 per cent increase during the last four years. In 1948 it averaged \$410 per year per employee.

The survey further points out that the benefits, reached mostly through voluntary collective bargaining, averaged 18.7 per cent of the companies' overall costs—or 31.5 cents a payroll hour.

\* \* \*

**Medina criticizes Hunt for security.** Federal Judge Harold R. Medina of New York said that "everyone seems to be looking for security." Boys just out of college ask personnel directors what the pension rights are and at what age they will be allowed to retire," he said at the summer commencement exercises of the University of Chattanooga. "Croakers abound everywhere telling us that everything is going to pot, that the world is plumb full of corruption and that nothing can be done about it.

"But the truth is that this do-nothing policy of playing everything safe is just about the worst thing that a person can do."

Turning to the Scriptural parable of the talents, in which those who traded and thus increased the number of their talents were commended while one who hid his talent in the earth was reproved, Judge Medina said that he believed this was a lesson "telling us, don't be afraid, don't be cynical, don't be lazy, keep plugging away all the time with zest and enthusiasm." The talent was both an ancient weight and unit of money. (N.Y. Times, 9-3-52)

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The predictions were, before the election November 4, that the top leaders in government would push a "real" retirement system. It remains to be seen what the color of those are who will operate our Federal Security Department under the new administration.

\* \* \*

You were good citizens—you went to the polls to vote—remain a good citizen—take a daily interest in your community and your government.

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# THE JOURNAL

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### THE CAROTID SINUS REFLEX:\*

#### 1. Clinical Manifestations of the Hyperactive Reflex

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*Mentone*

**I**N NORMAL MAN, the carotid sinus reflex is one of the mechanisms which regulates blood flow to various parts of the body. Hyperactivity of this reflex mechanism produces the syndrome, sometimes also called the cardio-inhibitory carotid sinus syndrome, emphasizing one of the three principal actions of the mechanism. The carotid sinus syndrome is important clinically because it may produce attacks of vertigo or loss of consciousness, convulsive seizures, generalized weakness, nervous manifestations, epileptiform attacks, and occasionally even more bizarre complaints. Inasmuch as it is a condition which can usually be treated satisfactorily, if correctly diagnosed, it is important to emphasize certain features of the clinical problem.

#### Historical Review

In 1799, Parry<sup>1</sup> first reported his observation that pressure over one of the carotid arteries caused slowing of the heart. Other authors subsequently confirmed this observation, but felt that the action was due to the direct stimulation

of the vagus by pressure. It was not until 1923 that Hering<sup>2</sup> in a series of brilliant experiments, demonstrated the true nature of the reflex mechanism involved. In 1933, Weiss and Baker<sup>3</sup> in a comprehensive clinical and physiologic survey called attention to the various clinical manifestations of the hyperactive reflex. In 1935, Ferris, Capps, and Weiss<sup>4</sup> again reviewed the clinical manifestations and added a large number of cases to their previously reported series. Since that time, the subject has been repeatedly reviewed in medical literature.

#### Anatomy and Pathologic Physiology

Weiss and Baker<sup>3</sup>, Arp and associates<sup>5</sup>, Nathanson<sup>6</sup>, and others have accurately defined the nervous pathways of the reflex arc. The carotid sinus is a bulbous dilatation of the common carotid artery at its bifurcation, and the reflex arises in nerve receptors in the wall of the sinus. Hering<sup>2</sup> demonstrated that the afferent portion of the reflex arc traveled through the carotid sinus nerve, a branch of the glosso-pharyngeal. The afferent impulses are transmitted to the vaso-motor and respiratory centers of the brain,

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\* This is the first of a series of three papers on the carotid sinus reflex. The series will appear in sequence.

to the superior cervical sympathetic ganglion and at times to the nodose ganglion of the vagus nerve. There are two separate efferent pathways which are well defined: by way of the vagus nerve to the heart (cardio-inhibitory effect) and by way of vasto-motor fibres to the blood vessels (vaso-depressor effect.) Weiss and Baker<sup>3</sup> demonstrated a clear-cut action implying a pathway to the medulla and from there as motor impulses to certain vegetative centers in the region of the hypothalamus or the blood vessels that supply such centers.

Three well defined types of response have been demonstrated:

1. *Vaso-depressor effect.* This action, mediated by sympathetic depressor nerves, resulting in reflex dilatation of the small blood vessels, is manifested clinically by a drop in blood pressure with associated symptoms. This may occur entirely independently of the second type of response or of the third.

2. *Vagal or cardio-inhibitory effect.* This is mediated through the vagus and is manifested by varying degrees of cardiac slowing. Actual cardiac standstill may occur, with asystole due either to sino-auricular or auriculo-ventricular block.

3. *The cerebral effect* is harder to evaluate, but consists of vertigo, weakness, and even convulsions, without associated bradycardia or hypotension. Weiss and Baker<sup>3</sup> felt that this was a very common type of response, but clinically it is more difficult to demonstrate.

### Incidence of the Carotid Sinus Syndrome

The actual incidence of patients with clinical symptomatology due to a spontaneously hyperactive reflex is hard to determine. Various figures have been published but are sometimes hard to evaluate. As will be emphasized later, it is not enough to merely report the incidence of patients who have symptoms when their carotid sinus reflexes are induced by external pressure. Many people who are entirely normal will demonstrate bradycardia, hypotension, and even unconsciousness or convulsions when the test is induced, but have no symptoms at all spontaneously. In discussing incidence of the carotid sinus syndrome we should therefore confine this classification to those patients who have clinical symptoms which are reproducible by carotid sinus pressure.

In our own series, we have found only 12 patients (out of slightly over 4,000 seen) who have filled all the criteria for the carotid sinus syndrome, patients whose clinical symptoms could be clearly and repeatedly reproduced by carotid sinus pressure. Many others have been seen who showed a classical response to such stimulus but were having no spontaneous clinical manifestations. This relatively low incidence may make the syndrome appear unimportant, but in view of the fact that it is so often misdiagnosed and is generally curable, it is important to review the clinical manifestations in detail.

### Technique of Inducing the Reflex

The carotid sinus lies at the bifurcation of the common carotid artery and can be felt just below the angle of the jaw, with the head tilted upward and away from the side being stimulated. (Fig. 1) This dilated portion of the carotid artery can be felt readily and should be maneuvered so that it can be firmly pressed against the vertebral process. Pressure should be made with at least two and preferably three fingers, so that the sinus will be well covered. (Fig. 2) Pressure should be initiated quickly and not gradually. Massage will often aid in producing the reflex. Pressure can be maintained up to 30 seconds, although a positive response may be obtained before that time, and pressure immediately discontinued. It is best to perform the test with the patient in a recumbent position at first, although the syncope symptoms may be better induced with the patient sitting up. A cardiogram may be taken during the test in order to demonstrate the cardio-inhibitory portion of the response. An assistant should record blood pressures during the period of stimulation. The examiner himself should be listening over the precordium with a stethoscope, so that he can immediately discontinue his stimulation if asystole is produced.

### Complications in the Test

Askey<sup>7</sup>, and others have pointed out the dangers in carotid sinus stimulation. Hemiplegia has not been uncommon. Many patients, in fact most of those with pathologic reflexes, are in the older age group, with arteriosclerotic arteries. In such patients, prolonged stimulation of the carotid sinus and resultant cerebral anemia may lead to irreversible cerebral damage. Such complica-





**Figure 1.** The black marker lies over the upper portion of the common carotid and the area of the bifurcation. This is the region where pressure must be applied, with care to assure that the pressure is over the carotid sinus itself rather than over the carotid lower down.



**Figure 2.** Method of applying pressure to the carotid sinus.

tions are infrequent and if the precautions outlined above regarding duration of pressure are carefully followed, such complications are extremely unlikely. Both carotid sinuses should never be pressed at the same time and it must be emphasized again that the physician applying the pressure should be simultaneously listening to the heart so that he can discontinue his stimulation as soon as the response is obtained.

### Symptoms of the Induced Reflex

When pressure is applied to one or the other carotid sinus in the manner described above, it may be possible to demonstrate various periods of asystole, electrocardiographically. The patient may develop marked hypotension without cardiac slowdown. Associated with either hypotension or bradycardia he may develop a feeling of weakness and vertigo. In patients with severe symptoms it may be possible to produce convulsions in this manner. Some patients may develop syncope, weakness, or even convulsions without bradycardia or hypotension (the so-called cerebral type of response). This type of clinical response, particularly syncope and convulsions, is best produced with the patient in the erect position, although it is as easy to produce asystole with the patient recumbent as erect. It is again emphasized that production of symptoms does not establish the diagnosis unless the symp-

toms thus produced are identical to or closely similar to those of which the patient complains.

### Spontaneous Symptoms of the Syndrome

It has been repeatedly demonstrated that the carotid sinus syndrome is most common in males, in elderly people, in those with hypertension and with generalized arteriosclerosis. Weiss and Baker<sup>3</sup> pointed out these contributory factors in etiology, and their observations have been amply confirmed.

These patients usually present themselves with a complaint of transitory or prolonged periods of unconsciousness with or without convulsions. The attacks may be preceded by an aura of vertigo, shortness of breath, nausea, weakness, tingling, profuse perspiration, or visual disturbances. Patient may already have observed that certain movements which produce pressure in the neck, such as turning the head quickly to one side, shaving with heavy pressure on the neck, or bending the head forward against the tight collar, will initiate an attack. Symptoms rarely occur in the recumbent position. Because of the brief aura, these patients rarely hurt themselves in falling. During their convulsions there is no biting of the tongue and no loss of sphincter control. There are sometimes vigorous clonic movements, localized or generalized. Unconsciousness may be very brief or may last 15 minutes or more.

Although we have pointed out the three modes of production of symptoms from a clinical point

of view, the resultant reactions are indistinguishable, whether produced by bradycardia, hypotension, or by purely cerebral effects. The clinical response is always produced by cerebral anemia, no matter how induced.

In an occasional patient the cardiac rate following the attack is increased, and the patient is conscious of this tachycardia. For this reason many of these patients present themselves as cardiac problems and have often been diagnosed as having "heart attacks". Inasmuch as they are in the age group who are liable to have evidence of cardiac disease, with coronary arteriosclerosis, bundle branch block, et cetera, the importance of the proper clinical diagnosis is obvious. The carotid sinus syndrome is a benign condition, usually responding to therapy. It must not be confused with more severe cardiac causes of unconsciousness.

Evans<sup>8</sup>, Rabwin and Merliss<sup>9</sup> and others have emphasized the possibility of confusion with various types of central nervous system disease. Because of the convulsive state a diagnosis of epilepsy has frequently been made on such patients. A search of epileptic hospitals has revealed a number of patients incorrectly diagnosed and completely curable by treatment of the carotid sinus reflex. For this reason it is emphasized that every patient presenting himself with convulsive seizures should be carefully checked for the carotid sinus response. If it is possible to repeatedly reproduce his symptomatology with this stimulation, he may be saved from the stigma of epilepsy. Inasmuch as the symptoms are sometimes unilateral, the possibility of confusion with localized cerebral disease is obvious.

Devries and Halpern<sup>10</sup> reported a most unusual response to carotid sinus pressure. This patient developed a feeling of pressure in the precordium with anxiety, dyspnea, and wheezing respiration. Prolonged pressure produced unconsciousness and right-sided convulsions. These attacks could be prolonged for as long as a half hour with the slightest stimulus. The authors were able to reproduce the attacks at will.

Urschel and Kraning<sup>11</sup>, and Schwartz and Eichna<sup>12</sup> have reported the occurrence of otherwise classical attacks of Stokes-Adams syncope which were reproducible by carotid sinus pressure. In both of these reports, the patients were completely cured by appropriate therapy.

Rovenstine and Cullen<sup>13</sup> have discussed the problem of the hyperactive carotid sinus reflex in anesthesia. It is quite obvious that undue pressure upon the carotid sinus area by the anesthetist during a surgical procedure might well result in catastrophe in patients with a hypersensitive reflex.

Draper<sup>14</sup> and others have discussed the differential diagnosis at length. Meniere's syndrome may be simulated. As stated above, a diagnosis of epilepsy is frequently made. Other patients are branded cardiacs.

Needles<sup>15</sup> has discussed in detail the nervous manifestations of this condition, and has pointed out that attacks may be much more frequent in nervous and tense individuals. The simple psychotherapy of a discussion of their problem and of reassurance by education may of itself result in less frequency of spontaneous attacks. The author has had this experience repeatedly. When the patients are reassured that their attacks are of no great consequence and can usually be adequately controlled with medication, it is often found that after a short period of time the medication can be discontinued and attacks occur infrequently.

### Treatment

Weiss and Baker<sup>3</sup> first were of the opinion that the syndrome was always associated with some local change in the region of the carotid sinus. Although this has been proven to be generally untrue, there may well be some localized tumor, scar tissue, or vascular abnormality producing pressure on the carotid sinus. For this reason, the involved region should be carefully examined and surgical exploration advised in the presence of localized glandular enlargement, massive scar formation, et cetera.

The patient must be educated as to the possibility of stimulation by a tight collar, by pressure upon the neck, or by sudden movements of the head. They can often learn to control their attacks by avoiding such physical situations.

As Needles<sup>15</sup> has reported, the anxiety state should be corrected. Nervousness and apprehension should be allayed. Excessive fatigue, worry and emotional upset must be avoided.

Sympathomimetic drugs are the treatment of choice from a pharmacologic point of view. Ephedrine or ephedrine-like products in moderate dosage three or four times daily are often



completely effective in relieving symptoms. The familiar combination of  $\frac{3}{8}$  grains of ephedrine with  $\frac{1}{2}$  grain of phenobarbital acts not only as a sympathomimetic agent, but the phenobarbital has obvious value in controlling nervous manifestations. Atropine sulphate in a dosage of 1/150 grains three or four times daily may be effective. Another familiar combination, of belladonna and phenobarbital, is often valuable. Thyroid has proven to be of help in some patients although the exact mechanism of its action has not been clearly demonstrated.

Surgical denervation of the sinus may be occasionally necessary, but should not be carried out unless the diagnosis is unequivocal, and unless all medical management has failed to obtain effective relief. Reports of poor results from surgical therapy have apparently stemmed from several factors. In some there has been an obvious mistaken diagnosis. In others the sinus has not been adequately denervated.

### Summary and Conclusions

1. The carotid sinus syndrome, manifested clinically by attacks of vertigo, weakness, and unconsciousness with or without convulsions, and at times associated with palpitation, tachycardia, precordial pain, nausea, tinnitus, profuse perspiration, or visual disturbances, is produced by hyperactivity of the carotid sinus reflex.

2. The carotid sinus reflex is a normal mechanism concerned with maintenance of blood pressure and cardiac rate. The pathologically hyperactive reflex manifests itself physiologically by bradycardia or asystole, by hypotension, and by cerebral anemia which may be unrelated to either of these responses.

3. The carotid sinus syndrome may be confused with organic cardiac disease, with epilepsy, with brain tumor or other localized cerebral disease, with Meniere's syndrome, with a Stokes-Adams syndrome, and with other conditions producing syncope, vertigo, weakness, unconsciousness or similar manifestations.

4. The diagnosis cannot be made by the mere production of bradycardia, or hypotension, upon carotid sinus stimulation. This response may be produced, even with unconsciousness and convulsions, in patients who have no clinical symptoms of hyperactivity of the reflex. The diagnosis can only be made in those patients in whom clinical symptoms can be completely and repeatedly reproduced by carotid sinus pressure.

5. The correct management of the syndrome lies in reassurance, prevention of fatigue and worry, avoidance of the physical conditions which may stimulate the reflex, in the use of the sympathomimetic drugs, and occasionally in surgery.

6. Because it is usually completely curable, and because it is often confused with conditions of much graver severity, it is important that the syndrome be generally recognized and appropriately searched for.

7. The method of eliciting the carotid sinus reflex is outlined and demonstrated.

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# DRAMAMINE FOR TOXIC LABYRINTHITIS INDUCED BY ANESTHETIC AGENT

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IN SO FAR as I can ascertain from the literature, the first use made of dimenhydrinate (Dramamine) for post-anesthesia nausea and vomiting was made by one of us.<sup>1</sup>

## Case Report

Mr. "B" had been operated upon twice before coming under my care.<sup>2</sup> The anesthetic agent for the two operations had been Pentothal Sodium. He was so pleased with its use that he requested this form of anesthesia for a proposed cataract extraction. Inadvertently morphine was given before the operation. This is not in keeping with our routine as it may precipitate nausea and vomiting.

Following the operation he was nauseated and vomited for eight days. Numerous therapeutic measures suggested by consultants did not benefit the patient. Vomiting was severe enough to rupture the eyeball, in spite of well-placed corneo-scleral sutures.

It was the impression of all concerned, including the patient, that morphine was responsible for the nausea and vomiting. Consequently Pentothal Sodium was used for anesthesia for a repair of ruptured wound.

The night after operation I made rounds and found the patient lying on his abdomen holding on to the bed with one hand and to an emesis basin with the other. Upon interrogation the patient described his feelings as follows: "Doc, if I were to leave loose of this bed, it or I one would spin out of the window." The similarity to motion sickness immediately focused my thought on Dramamine. One hundred milligrams of dimenhydrinate were given per rectum and the patient in one-half hour wanted to sit up and eat. This in contrast to eight days of nausea and vomiting previously.

This case occurred early in our experience with Pentothal Sodium in surgery of the eye. At the time we were giving little if any supple-

mentary anesthesia. The anesthetic agent was given in large doses to overcome a threatened loss of vitreous due to increased tone of the extraocular cone of muscles. Later we used D-tubo-curarine to accomplish this same effect with a much smaller dose of Pentothal. Nausea and vomiting were decidedly less. Nitrous oxide and oxygen are used as a supplement.

Large doses of Pentothal for total anesthesia was discontinued early in the series since all patients were nauseated and vomited. Most of them did not respond after operation for at least an hour, usually longer. In one instance the period was 12 hours. Dramamine was successful in controlling nausea in these cases.

When giving a large dose of one anesthetic agent it is much easier to approximate a toxic dose, than when a supplement such as nitrous oxide 75% and oxygen 25%, combined with D-tubo-curarine six to nine milligrams is employed.

We have employed Dramamine in well over 200 eye cases with excellent results. Both as a prophylactic dose of 100 milligrams by mouth one-half hour before surgery, and rectally 100 milligrams crushed and suspended in 20 cc of saline solution post-operatively.

Recently other essayists have reported excellent results with Dramamine for post-anesthesia nausea and vomiting: Rubin, Alan and Metz Rubin, Helen<sup>3</sup>, also Miller, D. K. and Henry, M. O.<sup>4</sup>

There has been some doubt on the part of general surgeons as to the efficacy of Dramamine in treatment of post-anesthesia vomiting. It should not be expected that dimenhydrinate, which has a quiescent effect upon the labyrinth, should favorably influence nausea and vomiting precipitated by other causes such as:

1. Psychogenic factors.
2. Reverse peristalsis as a result of intra-peritoneal manipulations.



3. Food intolerance.
4. Accumulated hypoxia and oxygen debt.
5. Hypotension.

It is thought that morphine may cause nausea and vomiting by reason of its cholinergic or anticholinesterase action, thus allowing more vestibular impulses from moderate motions to get through to the emesis center. The result is that transferring a patient from the cart to the operating table or back to bed may bring on nausea and vomiting, or motion sickness.

Dramamine, having an anti-cholinergic action seems to neutralize this effect.<sup>3</sup> Sodium Pentothal appears to have a similar effect to that described for morphine, when used, as it was earlier, alone or as the chief anesthetic agent for eye surgery. When used this way it was necessary to use large dosages as Pentothal is a poor analgesic but good hypnotic.

At present, Sodium Pentothal is used as a basal hypnotic adjunct to nitrous oxide anesthesia, with the addition of a small dose of curare. Nausea and vomiting have been greatly decreased. The use of Dramamine pre- and post-operatively has reduced the incidence of nausea and vomiting to the point that we are no longer forced to deny the comforts of general anesthesia to cataract patients. It will, presumably, not affect the nausea of peripheral origin, but may be expected to control that of central origin (toxic labyrinthitis).

Dramamine, being a combination of benadryl and theophyllin,<sup>5</sup> has some hypnotic or sedative effect of its own, and this effect must be remembered in gauging the dose of the pre-operative medication.

### Conclusion

Since its original usage we have employed Dramamine in well over 200 cases with excellent results in ophthalmic surgery. It is easily conceivable that dimenhydrinate can be successfully used in other surgical specialties not concerning themselves with intraperitoneal traumatization.

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### *In the Right Direction*

According to an American Medical Association report, American hospital service last year reached an all-time high.

In 6,637 registered hospitals, 18,237,117 patients were admitted, one every 1.7 seconds.

There was also a very marked gain in extending accident and health protection among the people, as measured by the accurate yardstick of premium income. This income for accident and health insurance increased almost 28 per cent over 1950. Blue Cross, Blue Shield and similar plans reported an increase of 14 per cent. Group accident and health insurance jumped nearly 41 per cent.

# THE DIAGNOSIS AND TREATMENT OF CARDIAC ARRHYTHMIAS

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**D**ISTURBANCES of the normal rhythmic beating of the heart are commonplace events in the experience of most physicians. It is difficult to fix the incidence of cardiac arrhythmias but the premise that everyone is at some time a victim of a cardiac irregularity will not be far from correct. The variety of patients presenting themselves with a disturbed heartbeat make it mandatory that physicians correctly recognize and treat the various types of arrhythmia.

The stimulus which excites the heart to rhythmic contraction is normally elaborated within the sino-auricular node at rates between 60 and 100 per minute, varying somewhat with the tone of the extra-cardiac accelerator (sympathetic) and depressor (vagus) nerves. This impulse is conducted radially through the auricular muscle to the auriculo-ventricular node where it is delayed slightly, and then transmitted rapidly through a specialized conducting mechanism to the inner surface of the ventricular wall. Any disturbance in the sequence of this basic activation pattern gives rise to a cardiac arrhythmia.

Considering that each myocardial fiber is capable of generating its own impulse, it is surprising that arrhythmias are not more common. However, the property of automaticity is usually of low order, unless heightened by some physical or metabolic irritant and the various myocardial centers are continuously being discharged by the impulse propagated from centers of higher irritability, i.e., the sino-auricular node.

Whenever an ectopic center becomes more irritable than the normal pacemaker it will control cardiac activity. If the aberrant stimulus appears only once, a premature contraction results; if it discharges repetitively and rapidly, a paroxysmal

tachycardia develops. As the ectopic pacemaker dies out, the sino-auricular node again resumes control.

Ever since the studies of Lewis and his associates,<sup>1</sup> the stimulus leading to auricular flutter and auricular fibrillation has been considered to circulate in the right auricle about the ostium of the superior vena cava. In the case of flutter the pathway was thought to be a fixed one and the circus to be completed from 200 to 400 times per minute with corresponding rates of coordinated auricular contraction. In auricular fibrillation the circus movement operates more rapidly (400-600 per minute) and, because of refractoriness of the auricular muscle at these speeds, follows an irregular course; again because of the refractory period all the auricular fibers do not contract with each circus, so that an uncoordinated twitching activity ensues. Recently this classic theory of the mechanism of auricular flutter and fibrillation has been questioned by experimental work<sup>2</sup> which suggests that auricular tachycardia, flutter and fibrillation have a common genesis in a single fixed ectopic focus and that the type of arrhythmia resulting depends only upon the rate of discharge of the stimulus. This unitarian concept is supported by clinical and electrocardiographic evidence.

Clinical problems generally concern four types of arrhythmia—supraventricular tachycardia, auricular flutter, auricular fibrillation and ventricular tachycardia. These have in common rapid, and sometimes irregular, heart action, which in itself may give rise to alarming symptoms and possibly constitute a serious threat to life. Occasionally the victim of such arrhythmia may be unaware of its existence but more commonly patients are frightened and distressed by the tumultuous precordial activity. The anxiety thus engendered may demand as much attention as the alteration produced in circulatory dynamics. Those with organic heart disease may also ex-

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hibit shock in varying degrees—weakness, giddiness, disturbed consciousness and circulatory collapse, or slowly or rapidly develop congestive failure. Patients with coronary sclerosis may complain of anginal pain and ultimately show electrocardiographic and clinical signs of myocardial ischemia from protracted coronary insufficiency. These symptoms are common to all the arrhythmias and vary only with the disposition of the patient and the degree of impairment in the heart itself. The individual features will be discussed briefly under separate headings.

### Supraventricular Tachycardia

Paroxysmal auricular and A-V nodal tachycardias are discussed together since the etiology, signs and treatment are similar. Occasionally even electrocardiographic distinction may be difficult. This type of arrhythmia is commonly seen in the absence of organic heart disease, when it may appear after sudden fright, excitement, digestive upsets, fatigue or severe exertion. When it occurs in association with organic heart disease, mitral stenosis, myocarditis, or coronary disease may be found. Subjects with anomalous auriculo-ventricular conduction (the Wolf-Parkinson-White syndrome) are prone to attacks of auricular tachycardia.

The diagnosis is usually made from the history of sudden onset and offset of attacks, constancy and regularity of rate during the attack and termination from carotid sinus pressure. The auricular rate varies from 140 to 200 per minute with corresponding ventricular response, although 2:1 A-V block has been noted occasionally. In infants the rate may reach 250 or more per minute without A-V block.

The treatment of paroxysmal supraventricular tachycardia first entails procedures designed to create increased vagal tone. The patient himself may try breath-holding, gagging and vomiting, and inspiration or expiration against the closed glottis (Valsalva and Müller procedures). The most effective technique for the physician is carotid sinus massage, carried out by compressing the bifurcation of one or other common carotid artery against the spine with the patient recumbent and the stethoscope applied to the precordium to detect the cessation of the attack. Pressure against the eyeball is unpleasant and usually worthless if carotid sinus massage is unsuccessful.

Should these mechanical procedures fail, drug treatment becomes necessary. Mecholyl and prostigmin subcutaneously induce strong vagal stimulation but may produce disagreeable or dangerous side effects which are relieved by atropine. However, their efficacy warrants continued trial in patients who do not have asthma, angina or myocardial infarction. The drug of choice, especially if organic heart disease is present or congestive failure impending, is digitalis. Full oral digitalization is recommended unless urgency warrants intravenous use, for which Lanatoside C (0.8-1.6 mg.) has enjoyed popularity. Quinidine should be tried if other methods fail; its use will be described later. Intravenous magnesium and oral potassium salts have also been recommended.

### Auricular Flutter

This is the least common of the auricular arrhythmias but often the most resistant to treatment. It occurs more commonly in subjects with organic heart disease such as rheumatic mitral stenosis and coronary arteriosclerosis. It may develop in hyperthyroidism, during pulmonary infection or embolism and during chest surgery. Flutter does develop in apparently normal individuals and can infrequently produce tachycardia with ventricular rates up to 250-300 in infants.

Clinical diagnosis is not always possible but auricular flutter should be suspected when a regular tachycardia with rates between 125-175 persists without change in rate from change in posture, exercise, breath-holding and the like. The suspicion may be confirmed if the rate decreases by a half or a third from carotid sinus pressure and promptly returns to its original level after release. The ventricular rhythm may be irregular if the degree of A-V block varies, but usually 2:1 to 4:1 A-V block permits a regular ventricular response. Rarely one may see very rapid waves in the jugular vein from transmitted auricular activity and very rarely hear faint auricular contraction sounds.

Digitalization is the treatment of choice. This drug may only slow the ventricular rate by increasing A-V block but this alone will be helpful. Occasionally digitalis may convert flutter to auricular fibrillation which usually reverts to sinus rhythm if the digitalis is stopped or, if not, when quinidine is given. If flutter does not stop, maintenance doses of digitalis must be con-

tinued, often in larger than usual amounts to maintain A-V block. If digitalis has not led to conversion to normal rhythm, quinidine should be tried, although it is not too effective in resistant cases. The clinician should be alert to detect an increase in ventricular rate following quinidine since quinidine may slow the auricular rate without proportionate effect on A-V conduction, and allow conduction to rise to 2:1 or 1:1 levels when the auricular rate slows to 200 or less.

### Auricular Fibrillation

This is the commonest arrhythmia requiring treatment in patients with heart disease. Its onset leads to a reduction of 25-40% in cardiac output, thus favoring the development of congestive heart failure; it promotes pulmonary or systemic embolization; it may precipitate sudden death.

Patients with mitral stenosis are particularly prone to develop auricular fibrillation and up to 20% of deaths in patients with rheumatic heart disease and auricular fibrillation are due to embolization from this arrhythmia. It is common in coronary heart disease and in thyrotoxicosis and develops in about one-third of patients with chronic constrictive pericarditis. Paroxysms may develop in subjects without obvious heart disease during respiratory infections, chest or abdominal surgery, pulmonary embolization, or without apparent precipitating cause. It is uncommon in syphilitic and in congenital heart disease and in bacterial endocarditis. The incidence increases with age and with the duration of underlying heart disease.

Auricular fibrillation is usually not difficult to recognize clinically. The ventricular rhythm is grossly irregular, a pulse deficit is found with faster rates, and the pulse amplitude varies from beat to beat. With slow ventricular rates the rhythm may be almost regular but exercise brings out the irregularity except when complete A-V heart block is present. Marked sinus arrhythmia, multiple premature beats and auricular flutter with varying A-V block may simulate fibrillation.

The treatment of auricular fibrillation depends upon the state of cardiac compensation, the duration of the attack and the precipitating factor, if known. In those paroxysms less than two or three weeks in duration reversion to sinus

rhythm should be attempted to prevent complications already mentioned. Quinidine and procaine amide are useful in this attack.

In protracted or chronic episodes of auricular fibrillation with structural heart disease, especially when congestive heart failure is present, digitalization is indicated to control the ventricular rate, eliminate pulse deficit, and promote efficient myocardial contraction. Once these ends have been achieved, the controversial question arises regarding attempts to convert fibrillation to sinus rhythm. The hazard of precipitating emboli has long been considered a contraindication to restoration of forceful auricular contraction. Recent experience with resumption of sinus rhythm in patients with chronic fibrillation has shown a surprising low incidence of unfavorable side-effects (in one series 2 of 200 patients developed emboli), whereas the expectation of complications from untreated auricular fibrillation is much higher. Specific indications for the use of quinidine in chronic auricular fibrillation are difficult to list for every situation, but Sokolow<sup>3</sup> has suggested the following groups: those without organic heart disease, those thyrocardiacs who continue to fibrillate two weeks after thyroid surgery, those with little cardiac enlargement or failure who are disturbed by the irregular precordial activity. Most cardiologists would attempt to revert chronic fibrillators who have developed embolization or whose congestive failure has not been satisfactorily controlled by the usual methods. Once sinus rhythm is restored, therapy with quinidine is necessary to prevent relapse of the arrhythmia, a problem particularly likely in patients with mitral stenosis.

### Ventricular Tachycardia

This ominous arrhythmia is prone to occur in victims of serious heart disease, particularly recent myocardial infarction, and may be the forerunner of fatal ventricular fibrillation. It may develop in patients with rheumatic heart disease, or with digitalis intoxication. About 10% of patients with ventricular tachycardia have no demonstrable organic heart disease.<sup>4</sup>

The rate may range from 140-250 per minute, but remains the same during individual attacks. The rhythm may be very slightly irregular and the first heart sound often varies in intensity.



Vagal stimulation will not alter the tachycardia. The jugular pulse is slower than the apical rate.

Quinidine or procaine amide is used to arrest ventricular tachycardia. These drugs should be given orally unless the patient is unable to retain the medication or urgency dictates immediate restoration of sinus rhythm. Occasionally, large daily doses of quinidine have been found necessary. Magnesium sulphate, morphine and atabrine have also been reported to stop ventricular tachycardia. Digitalis has been considered dangerous in this arrhythmia, but, if congestive failure becomes a serious problem, it may be used cautiously.<sup>5</sup>

### Anti-Arrhythmic Drugs

The action, administration, and side effects of most of the drugs mentioned in this review are well known and require no additional mention. However, quinidine has occasionally been regarded as too dangerous for routine use and abandoned where its effects might have been life-saving. Procaine amide has recently been introduced and its usefulness has not yet been thoroughly explored. This section will deal briefly with the important features of these two drugs.

#### Quinidine

The major pharmacologic effect of quinidine is prolongation of the refractory period of heart muscle; it also decreases the excitability of heart muscle, slows conduction through it and through the specialized conducting tissue in the ventricles, and depresses vagal activity. All of these properties enter into its anti-arrhythmic action.

A single dose of quinidine reaches peak concentration in the blood in two hours and declines to near zero at the end of 24 hours. If the same dose of quinidine is given at two-hourly intervals, the blood concentration reaches its maximum at the end of the fifth or sixth dose, and does not usually increase further if the dosage schedule is continued. If the administration is stopped after the fifth two-hourly dose, the blood concentration remaining at the end of 24 hours will average 40% of the peak level. If the same dose is given at 4 or 6 hour intervals, the maximum concentration is reached after two or three days.<sup>3</sup>

The administration of quinidine to patients

with cardiac arrhythmias is regulated by these factors. A test dose (0.2 gm.) to determine sensitivity is recommended, but may be dispensed if treatment is urgent. Quinidine may be given in doses of 0.4 gm. every two hours for five doses. If the arrhythmia persists after 12 hours, treatment is discontinued until the next day, when the same plan is resumed. The peak level will be higher on the second day since the base level from which treatment was begun was elevated from the drug given on the previous day. The same plan can be followed on the third day, if the arrhythmia has not stopped. Should the arrhythmia persist, the dosage should be raised to 0.6 gm. thereafter, and the same schedule continued. Careful attention is necessary for toxic manifestations as therapy progresses. If the arrhythmia is abolished, a maintenance dose of 0.4 gm., 4 times daily, for several days is recommended to prevent recurrence. In the case of chronic auricular fibrillation, it is often necessary to continue the drug for long periods, especially when mitral stenosis is present.

If necessary, quinidine sulphate (1.0 gm. dissolved in 200 cc. saline) or quinidine lactate (0.8 gm. in 100 cc. saline) may be given intravenously at the rate of 1 cc. per minute. Several preparations are available for intramuscular use.

It is incumbent upon all who use quinidine to understand the toxic potentialities of the drug. Among the frequent toxic symptoms are nausea, vomiting, diarrhea, tinnitus, nervousness and tremor. Less common are the effects on the heart itself: lengthening of the intraventricular conduction time and ventricular premature beats; paradoxically, quinidine may induce ventricular tachycardia. Rare effects are skin rash, fever, thrombocytopenia, and amblyopia. Sudden death during therapy has been attributed to asystole or ventricular fibrillation. Although the incidence has not been found to be as high as in untreated chronic auricular fibrillation, treatment with quinidine may precipitate embolization by restoring sinus rhythm.

#### Procaine Amide

Following the favorable results obtained from the intravenous use of procaine in cardiac arrhythmias, attempts were made to secure a re-

lated drug more stable in the body and free from the stimulating effects of procaine on the central nervous system. Procaine amide hydrochloride was found to fulfill these requirements, to be absorbed satisfactorily from the gastro-intestinal tract, and yield peak blood levels in one to two hours after an oral dose. Blood levels reach a plateau 36-48 hours after oral administration of fixed doses. As with quinidine, the drug prolongs the refractory period of heart muscle.

Procaine amide (Pronestyl) has been most useful in abolishing ventricular premature beats and ventricular tachycardia.<sup>6</sup> It has occasionally been found to be effective in auricular fibrillation of recent onset and supraventricular tachycardia, but auricular flutter has proven refractory.<sup>7</sup>

The drug may be given orally in doses of 0.75-1.5 gm. as often as every two hours, or as infrequently as every six hours, as the need dictates. Individual response varies considerably. Intravenous use is more effective and is generally safe if the administration of 50-100 mg. per minute, up to a total of 1.0 gm., is not exceeded.

Oral use may cause nausea and vomiting if the larger doses are given. Intravenous use may precipitate severe hypotension, premature beats, ventricular tachycardia, and intraventricular block, usually from rapid injection. Death from hypotension and ventricular tachycardia has been observed.

## Conclusions

The clinical features of the commoner cardiac arrhythmias causing rapid heart action have been reviewed. The diagnosis can often be made by examination of the patient but is usually confirmed by electrocardiography. Success in treatment depends upon accurate diagnosis and knowledge of the effects of drug therapy on the altered cardiac activity. The use of quinidine and procaine amide has been discussed briefly.

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# DIAPHRAGMATIC HERNIA

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**D**IAPHRAGMATIC hernia is diagnosed more frequently now than formerly. It must be considered in the differential diagnosis of lesions in the upper abdominal region and the lower thoracic region. The absence of the diaphragm is a rare condition. Eventration of the diaphragm is infrequent. Non-traumatic hernias are congenital while the traumatic ones are caused by either penetrating wounds or by a sudden increase in abdominal pressure.

Harrington<sup>1</sup> has prepared a classification of these hernias into non-traumatic, either congenital or acquired; and traumatic, either direct or indirect by crushing injury.

Congenital hernia occurs through the foramen of Bochdalek, the esophageal hiatus, the foramen of Morgagni (Larrey's spaces), or absence of the diaphragm. Acquired hernia happens through the esophageal hiatus (with sac), through the region of fusion anlagen of the diaphragm, or through the sites of congenital hernia.

Indirect hernia may result at any point of the diaphragm, through the esophageal hiatus (usually with sac), or through the leaf of the diaphragm (usually no sac). Direct hernia may be caused by missile or knife, or through a rupture due to necrosis from subdiaphragmatic abscess or caused by inflammatory necrosis in empyema.

## Anatomic Considerations

During the growth of the embryo from 2.1 to 20.0 mm., the separation of the celomic cavity into pericardial, pleural, and peritoneal cavities is completed. The ventral segment of the diaphragm grows from the intermediate part of the septum transversum while the dorsal portion develops from the mesoderm of the dorsal mesentery. The lateral segment is derived from the ingrowth rising from the septum transversum ventrally, and from the body wall laterally. These lateral portions develop toward the median plane to fuse with the dorsal portion.

A hernia is by definition a misplacement from a normal position. The congenital abnormalities which form before the fusion of the diaphragmatic leaves are not covered with serous membrane, and are not true hernias, since they never were in their normal location. Fusion is not, however, everywhere complete, and these residual openings are the site of potential herniation. Hernias at the dome of the diaphragm are acquired and not congenital.

The embryological weak points of fusion of the diaphragm are found at the following anatomical sites: first, the pleuroperitoneal hiatus situated dorsolaterally, the foramen of Bochdalek; second, the outer crus; third, the esophageal hiatus.

The hiatus pleuroperitonealis is a triangular space based partly on the 12th rib with its apex curved superiorly and anteriorly toward the central tendon. This occurs in children as a result of failure of fusion of the lumbar and costal portions of the diaphragm, and may persist in adults asymptotically as a space filled with connective tissue continuous with the iliac fascia. This is protected on the right by the liver; but the fibrous tissue is more easily torn than the surrounding muscle and is often the site of hernia, on the left in 95 per cent of the cases.

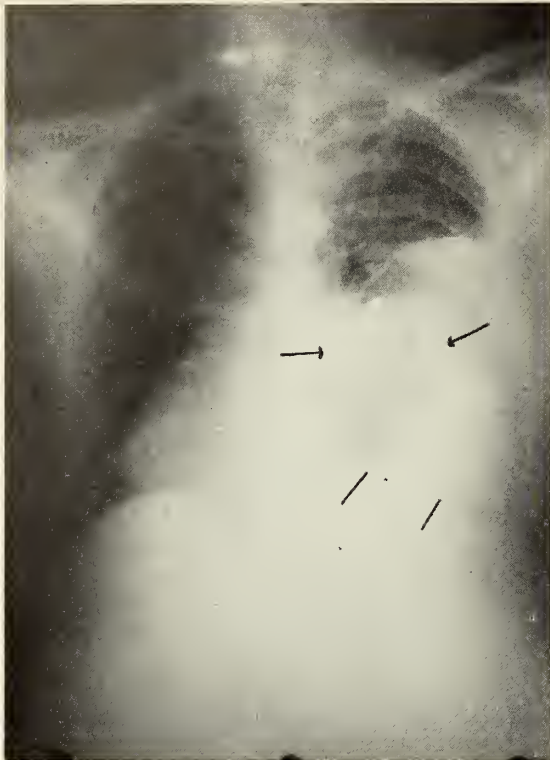
The foramina of Morgagni (Larrey's spaces) are openings on either side of xiphoid process of the sternum. They are filled with areolar connective tissue and are covered by pleura superiorly and with peritoneum inferiorly. They transmit the deep epigastric vessels.

The esophageal hiatus is formed by decussating bundles of the crura before they fan out to insert into the central tendon, and it transmits the esophagus, esophageal vessels and the vagus nerves. This is located at the level of the tenth thoracic vertebra.

## Non-traumatic

Non-traumatic hernias may be congenital or acquired after birth. Harrington,<sup>1,2</sup> Hedbloom,<sup>3</sup>

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**Figure 1.** Radiograph shows residual Lipiodol in the left lung (left arrow) and barium in the colon (right arrow). A section of the colon is delineated between the parallel lines.

Truesdale,<sup>4</sup> Ladd and Gross,<sup>5</sup> Marks,<sup>6</sup> Donovan,<sup>7</sup> Sweet,<sup>8</sup> and Meyer<sup>9</sup> have written considerably on this subject. Bowen<sup>10</sup> has prepared a review of the literature.

Congenital hernias most frequently occur through the pleuroperitoneal hiatus or foramen of Bochdalek. However, since these types experience such a high infant mortality, the most common adult type is the hernia which occurs through the esophageal hiatus. Hernias through the foramen of Morgagni, and the substernal hernias, are the least common. Congenital absence and eventration of the diaphragm have been reported.

Infants with diaphragmatic hernias are apt to experience severe symptoms, and surgical treatment is imperative within 48 hours. Any newborn infant exhibiting dyspnea, cyanosis, or vomiting during nursing or crying should be suspected of possessing a congenital hernia.

Esophageal hiatus diaphragmatic hernias must be differentiated from the thoracic stomach with a short esophagus. The symptoms of hiatus hernia simulate pulmonary, mediastinal, and

diaphragmatic cysts and tumors, gastric or duodenal ulcer, cholecystitis, appendicitis, intestinal obstruction, gastric or esophageal carcinoma, duodenal and colonic diverticulitis; or they may be coexistent. The symptoms of this type of hernia may depend on the size of the hernia. Ohler and Pitko<sup>11</sup> have described a hiatus hernia syndrome; a feeling of pain, fullness, or distress in the epigastrium and under the tip of the xiphoid is felt, and a patient often must stop eating, especially at the end of a full meal. If the patient walks, the symptoms disappear and eating can be resumed.

Small hernias do not produce many physical signs. In large ones percussion may locate tympany and auscultation may reveal a tinkling or splashing sound in the chest region. Examination by fluoroscopy with barium is invaluable.

A case of congenital hiatus hernia is shown in radiograph (Fig. 1), patient's age, 65. Her symptoms were not attributed to the herniation of the stomach and colon. Bronchoscopy and bronchogram reveal no pathology in the bronchial tree. The opaque material in hilar area is Lipiodol. Barium residual is present in colon above the diaphragm.

### Traumatic Hernia

Relatively large numbers of traumatic rupture were seen during World War II as the result of penetrating wounds of the diaphragm. Most of the cases seen in civilian life occur in automobile accidents. Fractured ribs are present generally in these cases.

In penetrating wounds of the diaphragm Hughes, et al,<sup>12</sup> states that vague pain occurs in the lower chest. At first the symptoms may be masked. Later epigastric pain may occur after meals and, when recumbent, flatulence, indigestion, and dyspnea may appear. The patient may hear gurgling sounds in the chest.

Dyspnea is present in sudden herniation. Pain, nausea, and vomiting occur. The lung collapses and mediastinal shift is often pronounced. Cyanosis is present. The patient too often dies before the herniation is diagnosed because of other fractures, especially skull, or before he is able to become a good surgical risk.

Diagnosis is aided by percussion of a tympanic area in the chest. Auscultation will reveal a tinkling or gurgling sound in the thoracic cavity.



Radiograph generally reveals a mediastinal shift. Abdominal viscera can be located in the thoracic cavity. The diagnosis in the case reported herein was accidentally made by aspirating the chest. The stomach was pierced. Air, fluid, and gastric contents were evacuated. After aspiration the viscera blockaded the rent in the diaphragm and in turn corrected the mediastinal shift. This procedure is certainly not orthodox, but might be employed in an emergency for poor surgical risks, if after the insertion of a Levin tube, suction does not empty the stomach contents.

### Case Report

A white male, aged 33, was riding as a front seat passenger of an automobile which was involved in a head-on collision. He anticipated the collision and turned his body to the right before the impact. He was thrown forward against the dashboard, striking and bruising the left lower chest, flank, and hip. The forehead, chin, and left elbow were cut by windshield glass. He was not unconscious, and noted immediate inability to breathe. He could not cough except in a forceful manner. Severe chest pain centered about one-half the distance between the left nipple and the costal border. Oxygen relieved his shortness of breath to a certain extent.

On the fourth day his chest was aspirated due to the mistaken impression that fluid was present in the pleural cavity. Gastric contents were obtained. Respiration improved; chest pain and discomfort was ameliorated. The senior author saw the patient in consultation and advised a bronchoscopy. The bronchoscopy cleared the air passage of mucus and some blood. Gastric suction drainage with gastric tube was instituted and maintained, but vomiting followed all attempts to take nourishment by mouth. The patient was supported with intravenous infusions and blood transfusions. His condition so improved, except for food intake that it was decided to wait a few days to repair his ruptured diaphragm.

Past and family histories were non-contributory.

Physical examination revealed the following positive findings: There was limitation of respiratory motion on the left. Increased breath sounds were present in the upper third and absent over the lower two-thirds of the left chest.

Gurgling sounds were present over the lower one-half of the left chest. Increased breath sounds were audible over the right lung fields. Borders of the heart were shifted somewhat to the right, and the point of maximal impulse occupied a position two fingers lateral to the sternum. Creptance of left seventh, eighth and ninth ribs could be elicited with marked tenderness upon pressure. There was moderate tenderness of the abdomen centering in the left upper quadrant. There was no abdominal rigidity. Extensive bruising of the skin in a continuous band was noted over the left lower chest, flank, and hip. An encrusted, circular, excavated wound of the left elbow, 2 cm. in diameter, was seen. There were linear shallow lacerations of the left leg near the junction of the upper and middle thirds on the anterior surfaces, and a marked contusion of the posterior muscle mass.

Laboratory examination: WBC 12,500; juveniles 1 percent, stabs 2 percent, segmented 70 percent, small lymphs 15 percent, and large lymphs 12 percent. RBC 5,000,000 with 14.5 grams of hemoglobin (100 percent Haden-Hausser). Bleeding time was one and one-fourth minutes and clotting time was two and three-quarters minutes. Blood type was "A", Rh positive. Postoperative WBC 7,700; myelocytes 1 percent, segmented 70 percent, small lymphs 20 percent, and large lymphs 5 percent. RBC 5,000,000 with 15.0 grams of hemoglobin (105 percent Haden-Hausser). Postoperative urinalysis contained a slight trace of sugar and a few hyaline casts.

Radiograph (Fig. 2) demonstrates herniated mass of viscera within the thoracic cavity. Stomach contains barium.

### Surgical Procedure

Prior to operation a gastric tube was inserted through nose to stomach. Under endotracheal anesthesia two sections of the ninth rib, which had been fractured, were removed. Surgical exposure showed that the spleen with yellowish, ragged margins of rupture had erupted to the thoracic side of the diaphragm. It was adherent to the lateral portion of the ruptured left diaphragm. The stomach and large bowel were encountered and freed from the lower lobe of the lung. The omentum covered a portion of transverse colon and both were included in the herniated viscera. The diaphragm was torn along a

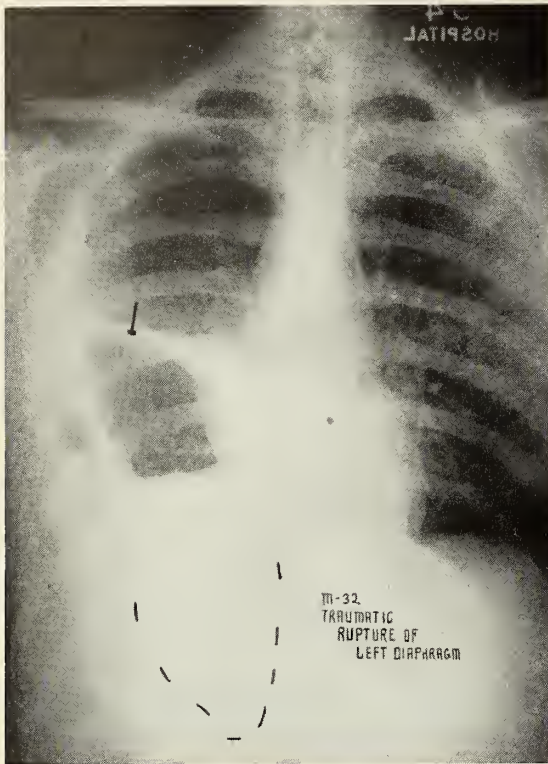


Figure 2. Radiograph demonstrates herniated viscera within the thoracic cavity. The stomach is outlined by barium and air.

linear curve extending in anterior-posterior direction about five inches. A two-inch extension of the defect was made with scissors in antero-lateral direction to facilitate reduction. The edges of the diaphragm were grasped with right angled hemostats and the stomach, small intestine, colon, and omentum were returned to the abdomen. Adhesions which had fixed the spleen in a position "rolled over" into the thoracic cavity were separated between the diaphragmatic pleura and the peritoneum. The spleen was delivered into the abdominal cavity after a few bleeding points were easily controlled by electrocoagulation.

Superfluous and necrotic diaphragmatic tissues were trimmed and debrided. The margins were approximated with a row of black braided No. 1 silk mattress sutures. These were reinforced with silk 00 single sutures.

A mushroom catheter was inserted through a stab wound in the fifth interspace. One million units of penicillin were injected into the thoracic cavity. The lung was re-expanded by positive pressure and underwater suction was instituted.

Three pints of whole blood were administered during the operation. Patient left the table in good condition.

Recovery was uneventful. Radiograph (Fig. 3) postoperative 4 days illustrates at 7 and 8 the sites of the fractured ribs and 9 the bed of the excised ninth rib. The upper arrow points to the left lower lobe while the lower arrow points to the stomach. Radiograph, (Fig. 4) postoperative 2½ months, demonstrates a flattened diaphragm and no recurrence of the herniation.

### Comment

This case illustrates that herniation through a ruptured diaphragm must be considered in those cases which have experienced sudden increase in abdominal pressure. Many of these patients do not recover from the initial shock and of course due to other complications, fail to live for surgical repair. Gastric suction may diminish respiratory embarrassment and shock due to gastric distension. It might be necessary to operate immediately to relieve distension and mediastinal shift. Endotracheal anesthesia is

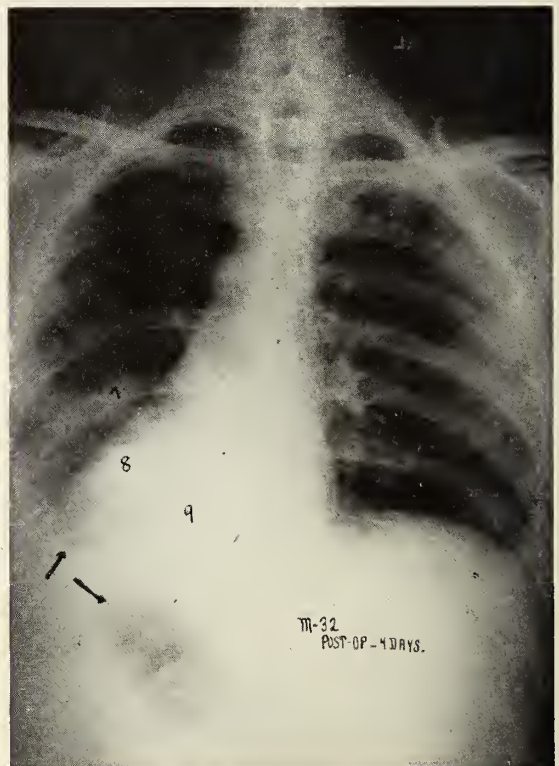


Figure 3. Postoperative radiograph shows stomach within the abdominal cavity (lower arrow) and border of re-expanding lower lobe of left lung (upper arrow).



indispensable. In an emergency, evacuation of stomach content by needle might warrant the chance of so doing as in this case. At operation the stomach may need to be opened and suction instituted before the stomach can be replaced into the abdominal cavity.

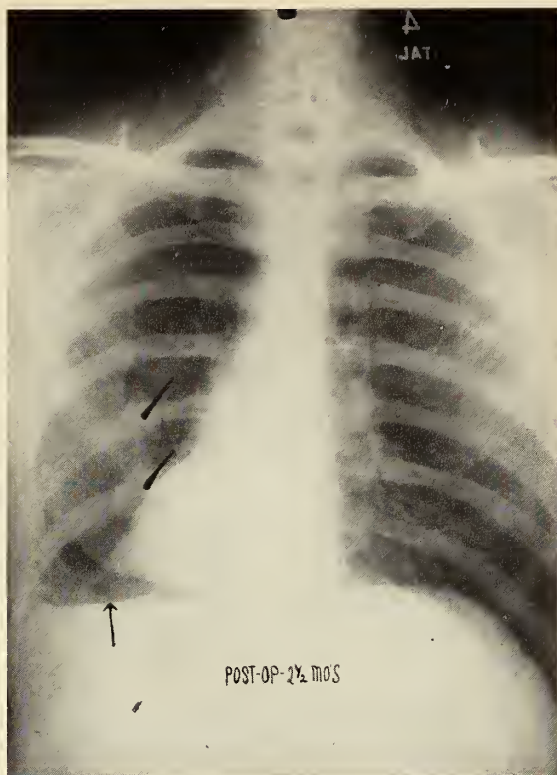
In the repair of traumatic hernias, the thoracic approach is generally agreed to be the most practical, since it provides better exposure and facilitates the division and separation of adhesions from the involved organs. The defect may be extended, or an additional opening created, in order to expedite the reduction of abdominal viscera. Interruption of the phrenic nerve is sometimes desirable. Underwater drainage should be employed for at least 24 hours. Antibiotics are important. Gastric suction is maintained if indicated. The delay of several days before operation made this patient an excellent surgical risk since his mediastinal shift was corrected accidentally.

### Summary

1. Diaphragmatic hernias, congenital and traumatic, are discussed.
2. A detailed report of one case of ruptured diaphragmatic hernia is reported. This case had herniation of stomach, omentum, transverse colon, small intestine, and spleen.
3. Surgical repair of the diaphragm is imperative either immediately or as soon as the patient's condition permits.

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**Figure 4.** Radiograph postoperative two and one-half months illustrates (club arrows) site of the fracture of seventh and eighth ribs. The left diaphragm (pointed arrows) is flat as a result of the repair.

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## MATCHING PLAN FOR INTERNSHIP

**A**LMOST all interns for the year 1952-53 selected their internships and obtained their appointments in accordance with an entirely new plan. An agency\*, formed by the various hospital associations, The Association of Medical Colleges, and the A.M.A., formulated a method for intern placement, known as the Matching Plan for Internship Appointment.

Each hospital was free to participate in the plan or not. Actually 795 hospitals with 10,414 intern vacancies joined the plan.

Senior students were also free to participate or not. 5,681 students signed agreements to participate.

Hospitals were not restricted in their efforts to interest students in applying for internships. Interviews and consultations with their prospective applicants were encouraged. All of the customary preliminaries were sanctioned, except that a binding agreement between hospital and prospective intern was not possible until the central agency had approved the selection.

The students were permitted to investigate the quality of internships by correspondence or by personal visit. They were privileged to apply to as many hospitals as they wished. A directory of all hospitals in the plan was furnished each student.

The heart of the plan lies in the method of matching the preference of the hospital with the preference of the student.

Each student, after he has submitted the usual applications to his preferred hospitals, sends a confidential report to the central agency, listing in order of his preference, the hospitals to which he has applied.

Each hospital, sends a confidential report to the central agency, and indicates the students who have applied to that particular hospital, in order of preference.

By means of punch cards, the preferences are matched in an orderly procedure, so that each student and each hospital receives first preference if at all possible. If this is not possible the

\* National Interassociation Committee on Internships.



system assures the matching closest to first choice in each case.

Actually 84% of the students obtained internships of their first choice, 10% their second choice.

74% of the internships were filled by hospital first choice and 18% by first alternates.

The hospital administrators of Indiana are expressing satisfaction with the plan as it functioned this year. They feel that it has succeeded in placing the interns in the hospitals they most desired, and has procured for each hospital the interns of their preference.

The matching plan is designed to eliminate the

time-consuming and frustrating procedures of the past. Several years ago students applied to several hospitals. When hospital selections were announced some of those chosen were found to have already accepted elsewhere, and hospitals with good internships were involved in a scramble for suitable applicants.

The present plan cannot and does not attempt to alleviate the problem which is created by the fact that there are some 5,000 more approved internships than there are interns. It does tend to fill all the best internships with the best applicants, and it has been able to accomplish this goal with a minimum of difficulty.

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## THE MEDICAL PRECEPTORSHIP

There is at the present time considerable interest among some of our doctors in the possibility of establishing a preceptorship program for medical students in Indiana. Such a program has been in existence in Wisconsin since 1926, and in a letter from the Executive-Secretary of the State Medical Society of Wisconsin, the following quotations are found which probably would be of interest to doctors here in considering this question:

"The preceptorship program in Wisconsin began with eight preceptors and now numbers 15. Since 1926 when the plan began, there has been only one withdrawal by reason of disagreement with the University policy.

"Ideally, the plan at Wisconsin seeks to provide the senior medical student with an opportunity for observation of medical practice in the office, in the home and in the small local hospital. It is believed that only in this way will the student reap the benefit of observing the sociological and economic side of medical practice so foreign to the wards of a large university hospital."

Apparently the students at the University of Wisconsin have been enthusiastic about this program, and it is stated that these young men often return to the area where they took their preceptorship to establish their practice.

"Some seniors have been heard to state that their preceptorial quarter was in their opinion the most valuable educational experience afforded them during their senior year in medical school. The student is made directly responsible to the preceptor and is expected to carry what-

ever work is assigned to him by this individual. The medical school requires that he keep a daily log of his activities to be submitted upon the completion of his preceptorship quarter. One of the doctoral requirements also is an original thesis or a case report amply supported by pertinent literature. The student is informed that such a report might easily be begun during his preceptorship period."

The one fault or drawback to this program that has been noted is that it adds a financial burden upon the senior medical student which he otherwise would not have. However, in any event he has to live and eat somewhere during those 12 weeks so that this would appear not to be too serious. The Wisconsin letter goes on to state:

"In this regard it might be interesting to note that 16% of the graduates of the University of Wisconsin Medical School are at present practicing in communities of less than 10,000 in Wisconsin. Of equal significance is the universal reaction of the preceptors that the quality of medical practice in their communities has improved apace with the development of this program."

There is no question in our mind that if the medical student benefits so much from a preceptorship, the preceptor himself will receive as much or more good from the process. This cannot help but make him a better doctor, and thus, the entire community will benefit from a plan which was intended in the first place to improve and put the finishing clinical touches on the education of the medical student. —A. W. C.

## Editorial Notes

Promiscuous use of combinations of antibiotics may result in one of the drugs deterring the effect of the other on a disease-causing organism.

Only if an organism proves resistant to a single antibiotic by laboratory test or adequate therapeutic trial should combinations of antibiotics be used, it was stated in the current (October 18) Journal of the American Medical Association. The report was made to the Council on Pharmacy and Chemistry of the A.M.A. by Dr. Ernest Jawetz and J. B. Gunnison, M.A., both of San Francisco.

They divided antibiotics into two groups: (1) penicillin, streptomycin, bacitracin and neomycin, and (2) aureomycin, chloramphenicol, terramycin and, possibly, sulfonamides. They said that a combination of drugs within either group will not antagonize each other and that simple additive effects from their multiple use are often observed. However, the combination of a drug in one group with one of the other group may interfere with the effectiveness of the drugs.

In addition the report stressed the disadvantages of taking fixed ratios of mixtures of antimicrobial agents prepared by pharmaceutical firms. The reasons included the possibility that (1) such mixtures may enhance the development of drug sensitivities in the patient, (2) the dose relationships for parenteral administration are often incongruous, and (3) there is little, if any, objective evidence to indicate that the mixture is more effective in a specific infection than is an individual component.

—*The American Medical Association*

"Dr. J. J. Johnson Day" in Milltown was marked by a parade, a reunion of many of the approximately 6,000 babies delivered by Doctor Johnson in his 50 years of practice in the

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**Two weeks after he was honored by his community, Doctor Johnson died. Full details will be carried in the January JOURNAL.**

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Crawford county community, and a general tribute by the many families which have been served by Doctor Johnson. The November 16 program was planned by friends in Harrison and Crawford counties.

At 82, Dr. William H. Larrabee, still practices medicine daily in New Palestine and has announced recently that he has no plans to retire. Already a Fifty Year club member of the Indiana State Medical Association, Doctor Larrabee celebrated his sixtieth anniversary as a member of New Palestine Masonic lodge on October 22.

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Dr. Joseph L. Hicks, oldest practicing physician in Hamilton county, is celebrating his sixtieth year in medicine and has been the subject of newspaper tributes in his home area recently. Doctor Hicks, a native of Kentucky and graduate of the Kentucky School of Medicine, has had a colorful career and tells in an interesting interview of the 700 typhoid fever cases he once cared for during an epidemic, the almost 5,000 babies he has delivered, and the 50 to 75 house calls he made daily during the influenza epidemic of 1918. Residents of Arcadia, his home town, express sincere praise for the unselfish service Doctor Hicks has given them for 60 years.

### Public Relations

A physician friend of ours says that his father, who is also a physician, once told him of three attributes which enhanced success in medicine. Each begins with the letter "A."

The first is AVAILABILITY. Patients like it. The conscientious physician knows that it is not only his duty but also good business to make himself easily available to his patients.

The second is AFFABILITY. Kindness, patience, tolerance, courtesy and respect for fellow men are necessary attributes of the good physician. That is affability. Patients like it, too.

The third is ABILITY. Each local scientific society is straining and tugging getting us to become better informed, keener and sharper. Patients have a hard time judging that attribute, but it constitutes one of our moral obligations to them.

—Bulletin Columbus Academy of Medicine



## *Letter to the Editor*

September 8, 1952

Journal

Indiana State Medical Association

1017 Hume Mansur Building

Indianapolis 4, Indiana

Dear Sir:

You may be interested in the enclosed opinion of the U. S. Court of Appeals for the Fifth Circuit in the case of U. S. v. Hoxsey Cancer Clinic, a Partnership, and Harry M. Hoxsey, an Individual. This opinion is the result of an appeal in a vigorously contested case tried in the U. S. District Court at Dallas, Texas. It reverses the judgment of the trial Judge (William H. Atwell, N. Dist. of Texas) and directs that Court to issue an injunction prohibiting the defendants from distributing in interstate commerce brownish-black, and pink liquids intended for the treatment of cancer in man.

In many parts of the country, people are taking the Hoxsey medicines in the belief that they may be an effective treatment for cancer. Friends and relatives of cancer victims frequently query local physicians concerning this treatment. You may wish to publish information about this case so that physicians will have the facts at hand concerning these drugs, in the event of such inquiries.

The following important principles are laid down in the Circuit Court opinion, based on testimony by cancer experts.

1. " \* \* \* there is only one reliable and accurate means of determining whether what is thought to be cancer is, in truth and fact, actually cancer. This requires a biopsy, a microscopic examination of a piece of tissue removed from the infected and diseased region."
2. " \* \* \* the opinion of a layman as to whether he has, or had, cancer, or a like opinion as to whether he has been cured and no longer bears the disease, if, in fact, it ever actually existed, is entitled to little, if any, weight."

3. " \* \* \* despite the vast and continuous research which has been conducted into the cause of, and possible cure for, cancer the aggregate of medical experience and qualified experts recognize in the treatment of internal cancer only the methods of surgery, X-ray, radium and some of the radio-active by-products of atomic bomb production."

4. " \* \* \* Upon such subjects a Court should not be so blind and deaf as to fail to see, hear and understand the import and effect of such matters of general public knowledge and acceptance, especially where they are established by the overwhelming weight of disinterested testimony \* \* \*."

The Hoxsey Clinic is located in Dallas, Texas, and ships its drugs to patients in many other States. According to the unanimous opinion of the Court of Appeals, consisting of Judges Russell, Hutcheson, and Rives, "the overwhelming weight of the credible evidence requires a conclusion that the representation that the Hoxsey liquid medicines are efficacious in the cure of cancer is \* \* \* false and misleading. The evidence as a whole does not support the finding of the trial Court that 'some it cures, and some it does not cure, and some it relieves somewhat'."

Under the law the defendants still have the right to petition for review by the U. S. Supreme Court.

Background information on the Hoxsey Clinic is given in the attached report prepared by the Division of Medicine of the Food and Drug Administration.

Very truly yours,

C. W. CRAWFORD,

Commissioner of Food and Drugs  
Federal Security Agency  
Food and Drug Administration  
Washington 25, D. C.

Attachment

Decision—U. S. Court of Appeals for the  
Fifth Circuit (Hoxsey—7-31-52)

Report on Background of Harry M. Hoxsey  
and Hoxsey Cancer Clinic.

# Medical Panorama by the ASSOCIATE EDITOR

## KEEPING UP TO DATE

Many of us have felt a good deal like Dr. William S. Reveno must have felt when he wrote an editorial for the *Detroit Medical News*, but we can't always find the right words to express said feelings. Good old Alcofribas himself would relish this one:

If your appetite for the dry medical literature coming to your desk is jaded and you're falling behind the scientific procession, try some of the sprightly stuff fed to the public in most of today's popular magazines. It will open your eyes to startling discoveries and useful hints you may never hear about if you limit your reading to the horse-and-buggy scientific journals.

In one recent month alone you could learn, along with your patients, about a new C-bomb that halts cancer; a new drug in tablet form that corrects the inherited nutritional deficiency responsible for alcoholism; what vitamins to give or take; how to save your patient's teeth; teach him to live with his ulcer; cure his constipation without drugs; and you can even learn how to detect dope addiction in the newborn! In addition, there are any number of brief timely tips all time-tried and proven that should be of immense help in your practice. Do you know that horse-radish stimulates bile flow and shortens the duration of infectious hepatitis; that butyl-amino-benzoate combined with procaine injected pre-operatively relieves post-operative pain, that gamma globulin protects against polio; that B complex with crude liver extract and a high protein diet is good for tender breasts; that window-shopping will divert the fatty from eating; and that sex-hormones can help the psychotic? Have you heard of the new drugs for arthritis and gout, the new nerve-cutting operations for Buerger's disease, new treatments for bursitis, hip-disease, Parkinsonism, histo-plasmosis, trichinosis, menstrual cramps and mental confusion in the aged?

Keeping up with these signal advances is a must—if only to be prepared for the patient who comes in with a self-made diagnosis demanding, "gimme some of this," as he hands you a clipping from his favorite magazine.

So great has the profusion of diagnostic and therapeutic hints by the lay press become, that the regular channels for their careful evaluation will soon be bypassed altogether. Don't be surprised if, in the near future, more of our professors and researchers will submit their manuscripts directly to the lay periodicals.

Better broaden your reading habits or you'll find yourself stumped and embarrassed by your patients.

Shades of Osler and Hippocrates! Do you suppose there's something to this?

## REDUCTION IN HOSPITAL RATES

The above startling headline appeared in the *Bulletin of the Academy of Medicine of Cleveland*, for August, 1952, and since perusal of the article thus titled showed it to be serious (should we say *glorious*) fact and not just another bit of satire, we have clipped same and present it here, for your delectation and encouragement:

July 1, 1952, St. Luke's Hospital reduced the Daily Service Charge, which is a partially inclusive rate, \$1.00 per day for all types of accommodations. Rates are set according to an algebraic formula originated by Dr. Fred G. Carter, Superintendent of the hospital, which gives proper weighting to the private, semi-private, and ward accommodations. Charges are based on the actual cost plus 10% to cover bad debt losses, inflationary trends and other contingencies.

A monthly summary sheet shows the Superintendent at a glance how rates compare with expenses, so that proper adjustments of the rates may be made. The recent reductions came about as a result of the excellent cooperation of the Medical Staff of the hospital and other personnel and high occupancies of accommodations.

As of June 23, 1952, when a patient is admitted to St. Luke's Hospital, a three-line plate similar to the "charge-a-plate" used by department stores is typed in the Admitting Office. This plate contains the name of the patient, his hospital unit number, doctor, age, sex, and service. It is sent to the proper nursing division.

On the divisions the plate is put in the proper room frame for use in an imprinter. Wherever the name or other information is needed, the plate is used to imprint the information in a matter of seconds rather than handwriting it. It is hoped that this will save the time of the physician and nurse and effect better patient care as the result of reducing time spent on paperwork at the nursing stations.

Note that "cooperation of the Medical Staff . . . and other personnel" is given part of the credit for this accomplishment. It is our conviction that medical staff members will always be ready to cooperate in any serious attempt to benefit their patients. Certainly reduction in hospital rates can be considered a great boon to any patient, whether he personally pays, or whether his insurance scheme pays. The former perceives the benefit at once, while the latter receives it indirectly from subsequent lowering of premium rates, or at least from a lessening of the pressure tending to raise premiums. If one hospital can do it, why not others?





## President's Page



Fellow Members of the I.S.M.A.:

THE CHIROPRACTORS are endeavoring to win public favor through friendships, not science. They have organized lay groups to support their campaign for changing the Indiana law in order to create their own Board of Licensure. Most of the argument centers around "civil rights" and "an individual's right to select the kind of a doctor he desires." It is imperative for you to see the Legislators in your district and submit to them the reasons for our objections.

Facts and not emotional appeal should be considered by Legislators, chiropractors, and physicians. Chiropractic is, according to Webster, "a system of adjusting joints, especially the spine, by hand for curing of disease." It comes within the scope of a healing art and hence their licenses should be issued by a qualified Board. The State of Indiana regulates the practice of the healing arts for the welfare of all the people. The present Board of Medical Registration and Examination is composed of seven members—five M.D.'s, one osteopath, and one chiropractor. This is a just proportion for 4,000 M.D.'s, 100 osteopaths, and 400 chiropractors. The latter received their licenses as a gift from the 1927 legislature. Since this time, chiropractors have not satisfied the state educational requirements. Instead of trying to improve their schools, they are spending money to influence people on a civil rights issue, to obtain their own board, and to flood Indiana with poorly trained practitioners. In the first place their schools are operated like any school for massage, while medical schools are not operated for profit. The qualifications of their instructors are quite questionable. Because of our objections osteopaths have and are continuing to raise their school standards. Why should not chiropractors do the same? The State of Indiana requires a law student to attend a minimum of five years, optometrists five years, pharmacists five years, dentists six years, osteopaths six years and veterinarians six years. If the Indiana Board requires six years for individuals to qualify for taking care of a horse, four years is certainly not sufficient to take care of a human being, regardless of the number of hours they spend in school.

Physicians are not opposing the chiropractic board because they fear competition although the chiropractors make this charge to win sympathy from the layman. Again, ask your legislator to find out if the schools of chiropractic have made any new discoveries which have lengthened the span of life 28 years in the last 50 years. Have they done any scientific research on chiropractic? Have they employed scientists to prove or disprove their theory of pinched nerves, the interference in their nerve force and bio-electroid energy (whatever that is).

Until their educational requirements are such that they can serve in the Army, Navy, and Air Force, they should not serve the people in Indiana. The people of Indiana should know that, to date, chiropractic is just a psychological fantasy, based on unproved and unscientific theories. As physicians we are interested in scientific requirements to protect the health and welfare of individuals, all of which may sound like common horse sense to you, yet the chiropractors may not think it even stable thinking.

*Paul D. Grimm M.D.*

P.S. The reduction of the national debt, which may come with the administration of General Eisenhower, may reduce us to driving teams of horses instead of automobiles, but that can be tolerated much better than eating them under an administration of Governor Stevenson.

## 103rd Annual Session



Delegates, upper left, and officers and guests, upper right, open the 1952 convention of Indiana State Medical Association with 7:30 breakfast in Athenaeum.



Intent on business of convention, delegates, above, scan handbooks and listen eagerly to speakers.



Dr. William "Harry" Howard, Hammond, right center, being escorted to rostrum as members give president-elect standing ovation.

Three representatives of Student A.M.A. attend House of Delegates sessions.





## "OUR HERITAGE--TO WILL"\*

J. WILLIAM WRIGHT, M.D.

*Indianapolis*

IT IS A sincere pleasure to welcome you to "President's Night" of the 103rd Annual Session of the Indiana State Medical Association. This night was so designated a few years ago by our beloved late executive secretary, Ray Smith. It was so designated as an evening during which the retiring President of the Association might prepare an evening of entertainment; as an expression of his appreciation, and to verbally voice his thoughts as he prepares to step down from the Presidency.

It is with a deep sense of gratitude that I stand here before you tonight. I am most humble in my acknowledgment of the great privilege that has been mine in serving, for the past year, as President of this splendid organization.

I wish to thank each and every member of this Association and the committees whose devotion to the purposes of our organization has made my term of office the most pleasant experience in my life. I also desire to thank the members of the Woman's Auxiliary for their hearty cooperation.

I firmly believe the practice of medicine is the greatest profession on earth. In the comparatively short length of time I have been permitted to observe our profession there has never been any deviation from the fundamental concept—that of preserving life.

Only through faith and tireless devotion to duty have the great forward strides been made in the practice of medicine. I feel Mr. Wade Arnold, author of *The Endless Frontiers*, has expressed this in finer words than I could command and I would like to quote his statement.

"Sometimes, one finds confirmation of a faith in unexpected ways. You wouldn't expect to associate the sentiment of good will with test-tubes in a laboratory, or belief in a way of life with

the perfection of a surgical technique. Yet out of my talks with the scientists and clinicians and doctors who supplied the raw stuff of *The Endless Frontier* came a heartwarming sense of essential rightness of what the American people are all about.

"The men and women of this series were free spirits in a free society, exuding enthusiasm about their work and making it easy to understand why Americans in this century have been able to raise the average life expectancy from 49 to 68 years. But, even more important, perhaps, than this temporal result, is the spiritual value implicit in the character of these people—their restless curiosity, their sense of dedication, their willingness to try and try again, their eagerness to share knowledge and to work together, and the calculated risks they take for the common good.

"These are qualities of inestimable importance to the world."

While we all abhor wars with all their related sorrows, yet men have emerged from them with greater medical knowledge. In the present Korean war, American battle casualties have the highest survival rate of any troops in history. Records reveal that of every 1,000 men wounded, 978 are alive today. The rate of saving life is twice as great as it was in World War II and almost four times as good as it was in World War I.

This is a great tribute to American medicine and the cooperation of the armed services in making possible prompt treatment of the wounded with the best in latest scientific methods and skilled hands. Mankind, generally, will benefit greatly by these experiences on the battlefield.

On the home-front we have seen many changes in our system of the practice of medicine—changes that are keeping pace with the changing world.

\* President's address, presented at the annual session of the Indiana State Medical Association in Indianapolis, October 29, 1952.

Physicians generally have provided for "around-the-clock" medical attention for their patients. A recent survey of medical care in our state reveals that hospital facilities are available to practically every practitioner, and every patient, within a radius of approximately 20 miles.

In our changing world, a great deal of our thinking and planning is influenced by so-called liberal philosophies. This doctrine has infiltrated our educational system, penetrated our churches as well as the political life of our great nation.

We will heartily agree with a liberalism which stands for "freedom of thoughts and beliefs" and "freedom for individual attainment, regardless of race, color, creed or social status."

But we cannot tolerate the kind of liberalism based on materialistic concepts which have overrun our spiritual thinking and turned us away from our fundamental faith in God.

The rock of faith upon which this great nation was built, was trust and faith in the Divine Providence. As surely as we stray too far from this basic principle, just as surely will we deteriorate as a great power.

Communism and collectivism are based on such dogma and present the greatest challenge to our generation. I was very much impressed with Westbrook Pegler's definition "Socialism is Communism with a long fuse."

For seven centuries beginning with the Magna Charta, our ancestors fought to restrict the powers of government as the way to gain maximum freedom and dignity for every man as a precious human being, and thus to achieve a better life and society. Liberalism in those centuries meant winning for man the right to solve his problems on his own. Our forefathers came to this country, not to get government to do things for them, but to get a chance to do things for themselves.

Our citizens need constantly to be reminded that this is our system, and that under it, the 7% of the inhabitants of the globe who live in these United States have produced almost as much wealth and have distributed it more widely than all the other 93% put together. We need not only to remind ourselves what has happened here—but why it has happened. It was because in the United States, more than anywhere else, any citizen could do whatever he had the urge and the capacity to do with any idea or ambition he had, as long as he did not interfere with the

right and opportunity of every other citizen to do the same.

Mr. D. A. Simmons, a very able lawyer, who assisted in writing the first regulations of the United Nations Assembly stated that "we have only one fundamental right, the right to be let alone." The right to security, the right to work, the right to medical care are not rights at all, but are aspirations which the individual can attain by work.

The physician today must be more than just a doctor prescribing for illness, he must be a citizen interested in civic affairs. We should be conversant with subjects pertaining to the welfare of the community as a whole.

As an organization we cannot indulge in political controversies—but as citizens—we can and should express our individual views and exercise our God-given right to vote the way we choose.

I might add here, that an examination of the American Medical Association by a government agency revealed no irregularities and therefore, did not make front page news. It would be interesting to know, whether or not, a similar investigation was made of the organizations which have dedicated themselves in support of the administration's policies.

A situation which still remains a threat to the freedom of the practice of medicine is the relationship between physician and hospital. There can be no doubt that the hospitals are attempting to enter the practice of medicine. This is a direct violation of the ethical law, inasmuch as a hospital, is a structure wherein physicians practice the healing arts, as individuals, and not as a part of the corporate structure.

Few realize, that in attempting to qualify as teaching institutions, so-called private, non-profit and tax free hospitals have sacrificed room and space. Residents have been employed as specialists and have failed miserably in their objectives. This policy has resulted in producing more specialists than either the profession or the public can absorb and has sidetracked the one who is the backbone of medical service—the general practitioner. As this trend appears to be somewhat general it must be assumed that the policy had its inception in national organizations.

This is a direct copy of the system which has ruined every country in which it was tried and from which there appears to be no salvation.



If we are to continue to furnish to our patients the best medical care in the world, we must be factual, we must repulse the efforts of a minority group to force us into mediocrity. We must be firm and decisive and we must determine whether or not we are to remain free men or whether we will become captive slaves.

In the words of Robert Burns, "Oh, wad some power the giftie, gie us to see ourselves as ithers see us."

In conclusion I would like to offer a verse given me a few days ago by my good friend, Mickey McCarty:

"He has achieved success who has lived well,  
laughed often and loved much:

Who has gained the respect of intelligent men  
and the love of little children:

Who has filled his niche and accomplished his  
talk;

Who has left the world better than he found  
it, whether by an improved poppy, a perfect  
poem or a rescued soul;

Who has never lacked appreciation of earth's  
beauty or failed to express it;

Who has always looked for the best in others  
and given the best he had:

Whose life was an inspiration;  
Whose memory a benediction."

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## DOCTORS HAIL REVERSAL OF TREND TOWARD STATE SOCIALISM

CHICAGO—Three former presidents of the American Medical Association, who headed up the National Professional Committee for Eisenhower and Nixon during the campaign just ended, have interpreted General Eisenhower's landslide victory as "a dramatic and emphatic reversal of the trend toward State Socialism in America."

The statement was signed by Dr. Elmer L. Henderson of Louisville, Ky., who served as Chairman of the National Professional Committee for Eisenhower and Nixon, and by Dr. Ernest E. Irons of Chicago and Dr. John W. Cline of San Francisco, vice chairmen of the Committee.

"General Eisenhower's firm stand against National Compulsory Health Insurance, or any other form of Socialized Medicine, should put an end, at least during the coming four years, to any serious consideration of this socialistic scheme in The Congress," said the statement by

the three former AMA presidents. "The people's mandate was very clear, because General Eisenhower's running mate, Senator Nixon, also is opposed to Socialized Medicine, and with relatively few exceptions, the members of the House and Senate who were successful at the recent election also were outspoken opponents of Compulsory Health Insurance.

"This is of great significance, for if the New Deal-Fair Deal regime had been continued in office, the drive to destroy freedom in medical practice, and to extend the socialistic program to encompass the other major professions of the country, would have been given increased impetus.

"There can be no question that General Eisenhower's election brought a dramatic and emphatic reversal of the trend toward State Socialism in America, even though we recognize, of course, that there were many other factors which contributed to his magnificent victory."

Despite cold winds, Hoosier doctors turned out in generous numbers for golf tournament and trap shoot.



Members of Fifty Year club and families below, attend reception; see chalk-talk artist and hear Riley poems.

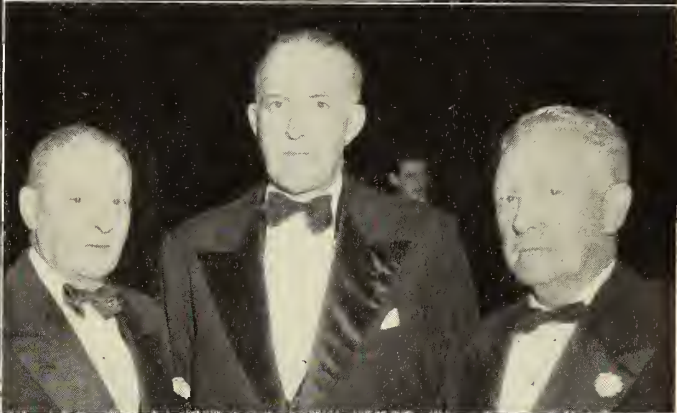
Below, class of 1927 I.U. School of Medicine gets together, and sports enthusiasts relax over coffee.



Banquet scenes on opposite page show traditional ceremonies, Auxiliary and ISMA officers, groups at speakers' tables with Dr. Edward J. McCormick, Toledo, AMA president-elect, speaking.







## WILLIAM H. HOWARD, M.D.

### President-elect

**D**R. WILLIAM HARRY HOWARD of Hammond was unanimously selected as president-elect of the Indiana State Medical Association at the 103rd annual session in Indianapolis on October 30, 1952.



Doctor Howard is past president of the Lake County Medical Society, and has been Councillor of the Tenth District since 1944. He was Chairman of the Surgical Section of the State Association in 1944, after serving as Vice-chairman in 1943. He is well known for his early and continuing interest in plans for the prepayment of medical care. He has been a director of Mutual Medical Insurance since its organization and is now its vice-president, and a member of its executive committee. He is also

a commissioner of the National Blue Shield Plans.

He was born at Remington, Indiana, on November 28, 1895. He attended Indiana University and received the B.S. degree in 1920, and the M.D. degree from Indiana University School of Medicine in 1922. His postgraduate training was in the form of an internship and a two-year surgical residency at the Indianapolis City Hospital. He has practiced in Hammond since 1925 and is now President of the Staff of St. Margaret's Hospital. He is a Fellow of the American College of Surgeons.

Doctor Howard, in addition to his many medical activities, has been interested in the civic affairs of his community. He is a member of the Hammond Chamber of Commerce, the Orak Shrine and the Kiwanis Club. He saw active service in the U. S. Navy in World War I.

He has served as a delegate to the State Association for many years, and has been a member of numerous Association committees.

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## REPORT ON TRANSACTIONS OF THE 103RD I.S.M.A. ANNUAL SESSION

**S**ECOND largest attendance at an Annual Session of the Indiana State Medical Association was reported at the conclusion of the 103rd convention. During the three-day meeting on October 28, 29 and 30 in Murat Temple, Indianapolis, 2,649 persons registered. Of the total, 1,323 were members, 542 were guests, 489 were Auxiliary members and 295 were exhibitors.

Attendance was maintained at a high level at general and section meetings, instructional courses and along "Exhibitors Row". Speakers of national repute presented excellent scientific papers, many of which will be published throughout the coming year in *THE JOURNAL*. Indiana specialists and general practitioners joined with these speakers on programs arranged for the

reinstated section meetings and a number of highly informative panel discussions were reported. Classes at the instructional courses were filled to capacity.

Both scientific and technical exhibits were of exceptional interest, with doctors and their guests crowding the booths at all times.

The official convention opened with the House of Delegates in session in the Athenaeum, where a silent tribute was paid to 31 former members of ISMA who had died during the last year. Each of those so honored had served in some official capacity.

Following the introduction of special guests and a message from Mrs. Hubert T. Goodman, Terre Haute, president of the Woman's Auxil-



iary, Dr. Paul T. Crimm, president-elect, addressed the delegates.

A previously approved change in the ISMA Constitution which would have abolished the office of Alternate Councilor did not pass on recommendation of the Council. A resolution concerning the reduction of dues to the Indiana State Medical Association failed to pass after the Council informed the House of Delegates that it was of the opinion the move would be financially unwise at this time.

Other action taken by the delegates included the favoring of a resolution on preceptorships, and the instruction to the President to appoint a committee to work with the Indiana University School of Medicine on plans to establish preceptorships between general practitioners and medical students for their mutual benefit and with the ultimate aim of equalizing distribution of doctors in the state.

Approved committee reports indicated there had been successful response to the telephone seminar and wire recorded programs which have been pioneered by ISMA for the benefit of county associations; the Medical Education Fund fell only a little short of the \$100,000 goal set and a new quota for 1953 of \$50,000 was set.

Favorable action was taken on the resolution to reestablish the Committee on Conservation of Vision; on the resolution which instructs delegates to the A.M.A. interim session to seek action reducing the number of required hospital staff and sectional meetings; on a resolution regarding the I. U. School of Medicine which asked that a previous resolution on problems concerning the medical school be referred to a committee named by the President; on the resolution concerning the problem of accrediting nursing schools in Indiana, asking cooperation of A.M.A. in improving the plan, and on a resolution calling for the establishment of a Medical Economics Commission, composed of members of the ISMA, representatives of I. U. School of Medicine and lay groups, such as Chambers of Commerce, service clubs, etc., to deal with the shortage of doctors which is deemed a problem of distribution rather than numbers in Indiana and to make a year-to-year survey of needs of communities, aiding in locating doctors and for the guidance of I. U. Medical School graduates.

Two resolutions dealing with the threat of socialization were passed. The first seeks a concerted grass roots educational campaign for members and seeks termination of laws detrimental to the medical profession, and the second, on the recent International Labor Organization convention, which through treaty powers, would force socialized medicine on the U. S. The latter action authorizes sending copies to all Senators and Representatives.

The House of Delegates did not favor the resolution asking that a pathologist be included in membership of the State Board of Health, nor the resolution regarding senior membership in ISMA. Likewise, they did not pass a resolution concerning official endorsement of activities, principles and policies of individuals and organizations.

In acknowledgement of his work in the field of research, particularly in vitamins, Dr. Stefan Ansbacher, Marion, was made an honorary member of Indiana State Medical Association.

A special committee report on special medical licensure was approved by the House with a view to advancing some legal plan to relieve the shortage of trained hospital personnel and the approval included request for adoption of the plan by the Board of Medical Registration and Examination of Indiana.

The Delegates also reaffirmed their previous stand on the issuance of two checks by Mutual Medical Insurance, Inc., when desired, one to the surgeon and the other to the participating doctor.

In still other action, the House of Delegates, selected Dr. John T. Kime, Petersburg, as Indiana's General Practitioner of 1952. Doctor Kime was one of three doctors nominated for the honor.

At the annual election of officers, Dr. William Harry Howard, Hammond, was named president-elect; Dr. Roy V. Myers, Indianapolis, treasurer; Dr. James W. Denny, Indianapolis, assistant treasurer; and Dr. Karl Ruddell, Indianapolis, was named to complete the term as A.M.A. delegate of Dr. F. S. Crockett, Lafayette, who resigned after serving many years.

The delegates gave a rising vote of thanks to Doctor Crockett and to Dr. H. G. Hamer, who expressed his desire to resign at the conclusion of his term at the end of 1952. Doctor Hamer

also served as delegate to A.M.A. for many years.

A.M.A. delegates named to serve until December 31, 1954 are Dr. Cleon A. Nafe, Indianapolis, and Dr. E. S. Jones, Hammond; alternates who will serve at the same time are Dr. Alfred Ellison, South Bend, and Dr. William C. Wright, Fort Wayne. Dr. Lall G. Montgomery, Muncie, was named alternate delegate to fill the term of Dr. Cleon Nafe, which expires at the close of 1953.

Following the brief acceptance address by the president-elect Doctor Howard, the invitation to hold the 1954 convention in Fort Wayne was accepted. The Annual Session in 1953 will be held at French Lick.

Various resolutions of appreciation were passed, expressing thanks to Dr. J. Neill Garber and the Convention Arrangements committee; to the press, radio, wire and TV services for their splendid cooperation; to the headquarters staff for the excellence of the 1952 Handbook for Delegates; to Dr. J. William Wright for his tireless efforts in behalf of ISMA during his tenure in office and to the Indiana State Board of Health for assistance in obtaining out of state convention speakers.

In a lengthy discussion on the report of the Committee on Veterans' Affairs and Rehabilitation, and following concluding remarks by Thomas Hendricks of the A.M.A. headquarters office, Dr. Lester D. Bibler, Indianapolis, and Dr. Truman E. Caylor, Bluffton, that section of the report on miscellaneous business was disapproved and it was suggested the incoming president name a committee to meet with proper organizations to work out a concrete plan to solve the problem under discussion. It was also moved that the committee be instructed to clarify the stand of ISMA through the press at the earliest possible time.

#### Convention Sidelights . . . .

Among distinguished guests who were in Indianapolis for the 1952 session were Dr. R. Haynes Barr, president, and Mr. Joseph P. Sanford, executive secretary, **Kentucky State Medical Association**; Dr. L. F. Foster, medical secretary, and William Burns, executive secretary, **Michigan State Medical Association**; Earl Thayer, secretary, **Wisconsin State Medi-**

**cal Association** and from **Illinois State Medical Association**, Dr. Harold M. Camp, secretary, Miss Frances Zimmer, assistant secretary, and Dr. Leo P. A. Sweeney, president.

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Seventy men participated in the **Indiana State Medical Golf Tournament**. Low score was presented by Dr. Paul G. Lindenberg, Indianapolis. Players were pleased with the numerous prizes awarded. Dr. T. A. Brady was chairman of the Golf Committee and was assisted by Dr. James McIntyre.

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Blankets, windbreakers and shirts were awarded the 13 members who entered the annual **Trap Shoot** during the 1952 convention of ISMA. Dr. Harold C. Adkins served as chairman for the affair.

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**Blue Cross-Blue Shield** generously sent a photographer to the convention, taking shots for **THE JOURNAL** and their own publications.

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**Dr. Frank Ramsey** was reelected editor of **THE JOURNAL** and an expanded group of associate editors will help during the coming year in establishing some new features. Associate editors will be **Dr. A. W. Cavins**, Terre Haute; **Dr. Stephen L. Johnson**, Evansville, **Dr. David A. Bickel**, South Bend and **Dr. Lall G. Montgomery**, Muncie. New members of the Editorial Board will be **Dr. Harold D. Lynch**, Evansville, and **Dr. Carl Culbertson**, South Bend.

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The GP of the year, **Doctor Kime**, had a full week during convention. In addition to his ISMA honor, he became a great-grandfather for the first time.

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Representing the Student A.M.A. at the convention were **Glenn Shoptaugh, Jr.**, president of that group at I. U. School of Medicine, and **Kenneth J. Rudolph** and **Charles L. Miller**, both I. U. students.

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Excellent performances were turned in by the **medical students** who served as pages during the convention.



## INDIANA'S GENERAL PRACTITIONER OF THE YEAR CHOSEN AT 1952 ANNUAL SESSION

**D**R. JOHN T. KIME, Petersburg, climaxed a colorful career on October 28 when he was selected the General Practitioner of the Year by the House of Delegates of the Indiana State Medical Association and subsequently was nominated as Indiana's choice for the "Family Doctor of the Year" award of the American Medical Association. Indiana won that honor in 1951 when Dr. A. C. Yoder, Goshen, was the national selection.

Doctor Kime, at 87, still practices medicine daily and "sees a number of patients that would be the envy of many young doctors today." Pike County Medical Society officers said in nominating him.

Born in a doctor's office, with his father, Dr. John Kime, standing by, John Thomas Kime has literally never been out of a doctor's office. As a boy, when regulations were not so strict and doctors made their own pills and extracts, John Kime served a valuable apprenticeship under his father, rolling pills, compounding tinctures and extracts, making ointments and even assisting in some minor surgical procedures.

His formal medical education started with a

**Among the first to congratulate Doctor Kime, 1952 GP, was Doctor Wright, who completed his term as president of ISMA at the close of the Session.**



**Dr. Kime receives gift from ISMA—oil painting of southern Indiana scene by Georges La Chance. Framed and bearing an inscription the painting was presented by Dr. J. William Wright.**

year at Indiana university, followed by two years at the University of Michigan Medical School and was then completed at the University of Louisville School of Medicine. He was

**Dr. A. C. Yoder, Goshen, ISMA and AMA "family doctor of 1951", chats with his successor, Doctor Kime, and Dr. William F. King, Indianapolis, chairman in charge of Fifty Year club reception and entertainment.**



graduated March 1, 1889, returned to Petersburg, Indiana, on March 11 and shortly after midnight accepted his first patient. He has now completed 63 years of medical practice in Pike county, during which period he has performed almost every type of surgery—much of it in private homes—and has attended three generations of some families.

Doctor Kime joined Pike County and Indiana State Medical Associations in 1889. He has held every office in his county society, served as secretary of the Pike County Board of Health and as a county coroner for two terms.

"My brother, Dr. Rufus R. Kime, who later

became a prominent gynecologist in Atlanta, Georgia, bought me my first horse to make calls. Later I graduated to a horse and buggy and then to an automobile. I've ridden or driven over every piece of road and lane within a good many miles of Petersburg in all kinds of weather. I never collected for that first case I took nor the \$4 worth of groceries I bought that family when I got back from delivering that eighth baby for them, but I've had a good life, a lot of interesting experiences, and have no intention of retiring for a good while," Doctor Kime said as he received hundreds of well-wishers at the Annual Session after announcement was made of his selection as GP of 1952.

### OLD DOC EWING HAS A REMEDY . . .

New York's largest newspaper—the Sunday News, which has a circulation in excess of four million—chided Federal Security Administrator Ewing recently for posing a problem and then solving it.

"Got to hand it to Ewing this time," the News said, editorially. "He has not only diagnosed an ailment which is creeping up on the nation, but has also come up with a remedy for it.

"The ailment . . . is a big percentage increase in older Americans. Our population has doubled since 1900. But in that same period, the number of people 45 to 64 years old has tripled, while the number of those 65 and up has quadrupled. . . .

"Oscar's remedy? He would bring the doctors under politicians and bureaucrats' control, like postmasters or income tax collectors, and dragoon all of us into a system of compulsory health insurance.

"The quality of U. S. medical service would promptly hit the skids, as happened in England shortly after the adoption of Socialist medicine there. Hospitals would deteriorate, doctors lose much of their morale, research lag, costs pile up.

"Net result: an almost unavoidable shortening of the average life span of Americans. A gruesome prospect, perhaps; but you've got to admit that Old Doc Ewing has a real remedy here for a dangerous state of affairs."



## MEDICAL CARE PLANS IN EUROPE AS SEEN BY AN INDIANA DOCTOR

WALTER U. KENNEDY, M.D.

*New Castle*

HERE are some basic matters concerning European practice that modify their methods and should be understood clearly by Americans. They show what an established custom can do to the bulk of the profession and since there seems to be a definite trend toward setting up the same set of dividing walls in our own profession, it is quite time we began considering whether we want any part of it. In every foreign country, the profession is divided into the specialist group and the general practitioners. The valley between them is wide and clearly defined with no method of crossing. A specialist may, if unsuccessful, become a G. P. but a G. P. never can become a specialist. Once in the G.P. category, he remains there permanently, no matter what his desires or his capacity for development.

Practically every hospital in Europe is owned or maintained by government and the same is true of every medical school and teaching clinic.

A student elects for himself at the close of his final year whether he will stay on in a hospital, if a position can be secured, and remain there in various promotion levels for the rest of his professional life, leaving only if he makes the top grade, to become a consultant, but always keeping a hospital part time connection. If the young graduate elects general practice, or cannot find a hospital opening in the lowest grades or if he fails to rise, he automatically becomes a G.P. and never again may he hope to attend a hospital patient. Such of his patients as desire or need hospitalization must be sent to new hands and the G.P. ordinarily has no voice in selecting the new attendant, unless he refers his patient to a "consultant", who is a graduate of the hospital system and retains a hospital connection.

The hospital man never has a practical relation in the basic human relations with a patient which we deem of great value. And the G.P., knowing he is sharply limited in caring for the patient, cannot develop the sound judgment of

the course of disease and tends to superficial interest in all he does. That possibly is the compelling reason why he accepts regimentation easily and is reasonably content with an assured income, even if small. And it is only in the countries where indemnity insurance prevails that one sees an alert, progressive and fairly prosperous profession. The full service or capitation method removes incentive for betterment and one does not have to go away from the United States to see operation of the same basic factors.

And it is also a fact, that wherever Socialism is rampant, full service schemes are in vogue.

And a further fact is that the material prosperity of individuals of the medical profession is exactly in proportion to the prosperity of the particular nation and the national prosperity in each European country is directly in proportion to the extent of Socialistic doctrine in the nation's government.

While this journey of observation began in Scotland and then England, as a return to England was made, it will be described last.

### Dutch Plan Working

In Holland one is immediately and forcibly impressed with Dutch prosperity. Business is booming, money holds its value, food is abundant and reasonable, the streets are crowded with well dressed people, patronizing fully stocked stores. The great bombing damage inflicted by the Germans on Rotterdam and the Hague, has been completely restored by modern buildings, the dike system has been rebuilt, the windmills are gone, the roads are in fine shape and everywhere on the farms are motorized tools. The profession shares in the prosperity. As usual the government owns the hospitals, they are staffed by permanent men but a G.P. may take his patient in and care for him subject, of course, to the doctor's training. But only the indigent has free hospitalization and care. The rates are low, un-

believably so, but the patient pays the low rate and pays his own doctor. Indemnity insurance against sickness, disability, surgery and obstetrics is universally held. The indemnity rates are low but so are the professional fees. The indemnities pay 4 guilders of the ordinary 6 guilder office charge and 6 of the usual 10 guilder house visit. The government requires insurance to be carried by all having over a minimal income and up to what would be a \$5,000 income here though the actual amounts are lower. Yet living costs are much lower. The Dutch have had little help from us and need none. They pride themselves on their individuality and self sufficiency and, of course, are strongly against Socialism and Communism. They provide for their own old age by savings or insurance but take good care of their indigent elderly.

Denmark is the original home of co-ops. They, by law, cover every section of the country, dominate all industry and production and have evolved a medical care plan which is efficient, satisfactory to doctors and low in cost. To me it seems the best system of all Europe, one I would like to see adopted, in part, here, but it would not completely fit us. The government requires establishment of sufficient co-ops, supervises them only to insure solvency and turns the entire medical management to the Danish State Society. Membership in a co-op is required of every person from 18 to 60, but is of two classes, active and passive. The passive group embraces those who so elect and those with a \$5,000 income. They pay a nominal annual fee and may change to "active" up to age 40. They pay their own medical bills and are not eligible to the after 60 old age pension. The active members get free medical care and hospitalization, which is paid for them by the co-op and also a retirement pension.

Every person with an income over \$300 a year pays a small fee (about \$2 annually) into a special medical pool fund. This fund is administered by the government, though details are in the hands of the medical society and from it, the charges of physicians, for each individual service to an indigent, is paid and also the hospital charges. An income of less than \$300 a year establishes indigency.

### **You Can Always Get A Doctor**

The government owns the hospitals, pays the staff salaries and upkeep. Usual charges are

\$6 to \$8 a week which includes everything except a tip to the nurses on leaving, which is a fixed custom. The staff salaried men are permitted to do a sharply limited outside practice. But the G.P. must give up his patient if he is sent into the hospital, if the co-op pays. In each co-op an agreement is made with the doctors in the area on the fees to be paid. They may elect charges for each service or a capitation fee and the majority of doctors in each co-op sets a plan, applicable to all. The medical group may ask for fee charges at any time and if denied by the co-op, an appeal goes to the Danish State Society, which finally fixes the rate.

They have an amusing custom of ensuring round-the-clock service. Any doctor may decline a call except the junior doctor, who must attend.

Passive members of the co-ops or those having over \$5,000 a year pay their own bills for hospital and doctor but every one of them carries indemnity insurance providing about 75% of the cost. The insurance companies are all private companies.

Denmark, like Holland is humming with prosperity. There is no unemployment, abundant foods, plenty of amusements, good clothing, excellent stores and a lavish hospitality to the visitor.

Copenhagen, I now think, is the most attractive city of Europe. Clean, brilliantly lighted, good hotels, the finest amusement park in the world, theatres and parks and restaurants with plenty of drinking fluids. Its hospitals are very modern, the standard of work equal to our own and more international medical meetings are held there than in any other city of the world.

Fees, like all the costs of living, are low. But all the medical men I met are prosperous as well as busy.

Here again is a prosperous country, individualistic, using a co-op system completely controlled by the members in small groups, a satisfied profession, low taxes (for their army is merely a police force) and having a fanatical hatred of Germany for unnecessary regimentation and oppression. This will be referred to in comments on the U.N.

The Swedish medical setup is much like the old German plan. Time was not available to secure accurate data but, in general, the profession is dissatisfied and a plan similar to the Dutch likely will be adopted. They have a com-



pulsory setup and the demand is for an indemnity plan.

A 500 mile motor trip through northwestern rural Germany did not permit inquiry and answers to letters have not yet come with details. I doubt if there is yet a definite plan. German doctors have no real organization, have little influence politically and have been regimented so long, they probably will accept whatever is proposed. A profession, not militant, meekly accepts, where by adequate organization, they could secure adequate standing for their own and the public benefit.

This great rural area we passed through is depressed, poverty stricken and apparently stunned. The houses are no longer well-kept, the windows are unkempt, machinery is not seen and the people are ragged.

The great city of Hamburg has hundreds of blocks of damaged buildings and I saw not one attempt at rebuilding. The same picture is seen in Bremen, mute evidence of the destructive ability of American bombers.

In Belgium, prosperous and showing its prosperity, there was little war damage except around Antwerp and Liege but this has all been rebuilt.

The medical care plans are the same as pre-war. Compulsory taxation by the government which makes low fee contracts with local medical societies. Medical men get better pay than skilled workmen, living costs are reasonable and doctors live in nice homes, most of them have cars, which in Europe bespeaks prosperity as they know it.

### Prices Are Astronomical

France is a chaos, politically and economically. The higher echelons of government expect to be in office temporarily and trying to get information is exhausting. Although armed with splendid letters, no one in the higher offices knew anything. Always a polite reference to someone lower in rank. In general, each worker must pay a tax which is administered by the Commune, which is a political subdivision like our counties. The worker pays his doctor the full charge and is reimbursed about 60% with a limit. Money is nearly worthless; a dollar now buys 450 francs against a pre-war 5. Prices have increased to astronomical heights, a newspaper costs 50 francs, a suit about 75,000 and an ordinary meal

700. One carries 5 and 10 thousand franc bills and makes change only with 100 francs. Medical fees run from 500 to 750 for office visits and 1,500 for calls. The factory workers only are covered. Hospitals are either government or religiously owned, with low charges, staffed with poorly paid but competent men. As usual, the G.P. has no hospital connections.

I say nothing of rural or small city France but those people are frugal and always have some money. Paris is shabby, there was no war damage but it needs paint and repair everywhere, the stores largely live for tourist trade. For the French trade, the goods are poor quality, scanty and high priced. Unions are the curse of France. They dominate factory management, limit production and members work little. Taxes are high but badly collected and wasted. France has lived only with our help and to think it can presently produce an equipped army is only wishful. The French fear the Germans and dislike almost every other nation. They can and will fight if cornered but someone else must furnish the equipment and also pay a large land army and they think we should do this. As a matter of cold fact, our lavish expenditures have brought us no gratitude, only superficial friendship. Whenever we cease pouring money into Europe we shall be without real friends there. And the notion that Europe will furnish 100 real divisions for the U.N. army is a splendid but fantastic dream.

Russia at this time could march to the Atlantic in a week in so far as land troops are concerned and their only real opposition would be a few American divisions. Germany can produce real fighters but all the other European nations hate and fear her and the notion of a United Europe is only a beautiful dream. They might rally behind a hundred American divisions provided we equipped and supported their own forces. And, strangely enough, there is a general indifference to the possibility of war. We worry very much more than they do. And now to England and Scotland with their glittering Socialist plan. It reminds one of a fine Swiss cheese. It looks solid but when cut the holes show. But it is only a part of a national Socialism which keeps the nation bankrupt. Never before have the workers had it so good. They work 30 hours a week and have unemployment, disability and health care. There are a few flies in the ointment. Insufficient food, insufficient and low

quality clothing, miserable housing, poor transportation and high taxes. But good medical care and hospitalization, if they can get it. Not a single new hospital bed in 10 or 12 years, though demand is so great that one waits 2½ years for non-emergency hospitalization.

The plan promised new hospitals, new medical centers, new ambulance and nursing services, free medical supplies, new teeth and spectacles and many other things. The trouble is that they get none of these things and the cost of the scheme, as is, is triple the estimated cost, and growing—even if free teeth are out and spectacles require payment of 50% cost. Prescriptions now cost a shilling each. But the doctors are doing very well and the average G.P. is satisfied. He is making a larger income than ever though there is the minor drawback of a very high (even to us) income tax. The specialist group never had it so good (but always remember the income tax of 40% to 98%). Of course, it is a fact that no person in England, even if he made a million a year, can keep more than \$25,000.

The plan provides for a payment by the worker (or other person) of about 75 cents a week for the entire plan (unemployment, disability, old age pension and medical). This covers the head of a family and children up to 18 (if not working). The wife, adult children or working children (and most of them have to work) pay the same amount each.

### Doctors Sharply Divided

Here again are the two classes of doctors—the specialist and the G.P.—whose beginnings have been previously described. The specialist is the hospital man, drawing a very modest salary from government and barred from accepting other compensation until he is important and old enough to separate himself partially from the hospital and set up as a consultant with part time hospital pay.

The G.P. is that and nothing more, and never can be more. The hospital is closed to him. He may secure a panel of not more than 4,000 patients, usually fewer, but may add 2,000 more for each full time assistant. He receives 17 shillings (now about \$2.40) per year for each registered patient plus some occasional extra shillings for special certificates, all this splendid (!) pay also is divided about 50-50 with the tax

collector. He goes when called and that is rather often. He tries to see all who come and that is a good many. He doesn't have to handle fractures or obstetrics or very sick people. He may prescribe anything in the official book, but he does have one privilege, he may send his patients to a hospital any time (if they can get in) and that is a helpful way of disposing of a really sick patient. Originally he is a well-trained man but he gets to be expert on colds, backaches and constipation and not much else. Of course, he also has some record keeping and certificate of disability signing. Usually he and his wife can keep this up by working nights and Sundays. Recently, a small raise in pay, averaging 10 shillings a year, and a small back pay allowance has been given and a gratuity for the first three years of practice has been allowed.

He can locate anywhere if he gets permission and he can change to another place if the doctors there agree but frequently they do not. Practically every doctor in the country is in the plan. He may stay out but only a few wealthy elder men do, for 97% of all patients are on panels. If he doesn't join the scheme, his practice cannot be sold (a common former custom) and if he dies, the widow may not rent his office to another doctor. If he goes in, he gets a small retirement pension (subject to income tax).

But the specialists have learned how to beat the scheme. All hospitals were taken over (and no new ones built) but there is a private institution known as a nursing home which may be from 5 to 200 beds. If one has a non-emergency disease (hernia, gallbladder, prostate, ulcer, etc.), and is not content to wait 2½ years, they may enter the nursing home and the specialist may treat the patient at the patient's private cost. But most patients haven't that kind of money. Before this scheme was adopted, the so-called "friendly societies" handled all the insurance. With the advent of the national scheme, they were expected to go out of business. But they didn't. They organized something like our Blue Shield and Blue Cross and sold indemnity policies, mostly surgical care. Under the English plan, when a patient is sick at home, he draws a weekly payment. If he goes to a regular hospital, the sick payment is not made. However, a nursing home confinement does not count, so the patient insures himself, gets the sick pay from the government and the indemnity from the in-



insurance company. So, at minor cost, he gets surgical care without waiting 2½ years. The insurance companies, all privately owned, and making a lot of money (subject to income tax) can afford to make a very low rate (about \$25 a year) as the utilization is much lower than our normal rates. They have grown to great size, one of them having twice as many subscribers, as our largest Blue Cross plan. The specialists gladly send patients to these homes and get private pay which gives them incomes much greater than ever before (of course, there's the income tax).

In all, in former years the average English doctor worked very hard for grossly inadequate incomes and most of them heartily condemned the existing system. To my great surprise, I found nearly every one satisfied and every specialist asked was enthusiastic.

### Attitude Shortsighted

But they don't look ahead. They have overlooked what the German doctors learned the hard way. The present scheme is costing the government so much and the cost is rising monthly so that the national economy cannot support it. So far the generosity of our own government has given them enough to meet the losses but we stopped the English subsidies and the English

cash reserves promptly went down to the verge of national bankruptcy.

Immediately the benefits were lessened, though against tremendous outcry. Politically, that is suicide. One may reasonably expect that the German experience will be repeated. The protests of doctors are not of much political importance there so they eventually will get lower and lower pay. Such has been the experience of every nation adopting compulsory health insurance under governmental control.

"From this and these, O Lord, preserve us."

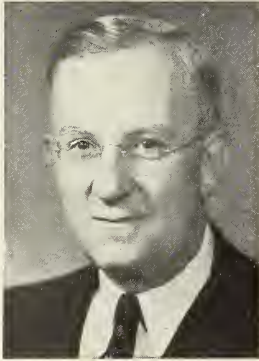
Finally, the Dutch and the Danes are the only European nations that have fair workable and equitable medical schemes. Neither of them are governmentally controlled and both of them are of the indemnity type. The French scheme looks good but is too limited in eligibility and uneven in operation.

Socialism is a deadening equalizer which destroys initiative, lowers standards of living, penalizes ambition, and paralyzes progress. It destroys usefulness of citizens by lessening the natural urge for betterment and limits savings and ownership, promotes indigency and destroys generosity and charity. The proof is clearly evident in the history of every compulsory, governmentally controlled medical care scheme.



## Deaths

**Albert M. Mitchell, M.D.**, 64, who had a long and distinguished career in Indiana medicine, died November 10 in his home in Terre Haute. He had been in ill health for two years. Doctor Mitchell had been a Vigo county physician and surgeon since 1914 when he returned to his home city



after receiving his medical degree from the University of Louisville and serving his internship in Grace hospital, Detroit. He was president of the Indiana State Medical Association in 1939; served as Fifth District Councilor for several years being named Council chairman in 1946; had been alternate delegate to the American Medical Association conventions for a number of years; was the first secretary and later president of the Terre Haute Academy of Medicine; had been medical examiner for Civil Aeronautics Administration since 1928 and was president of the Aero Medical Association.

Doctor Mitchell served Vigo County Medical society as its secretary for 30 years, holding that office at the time of his death. In 1925 he served as president of that group. He had acted as chairman of the annual Secretaries Conference of the Indiana State Medical Association for 13 years and from 1947 to 1951 conducted a similar conference for American Medical Association.

Doctor Mitchell served for two years in the U. S. Navy during World War I and was medical officer for the U.S. Navy V-5 unit stationed in Terre Haute during World War II.

**Russell Philip Schuler, M.D.**, 69, died October 24 in his home in Kokomo. A native of Wabash county, Doctor Schuler attended Franklin college where he played football and basketball and coached in those sports. Later he graduated from the University of Chicago and received his medical degree from Rush Medical

College. Doctor Schuler practiced in Kokomo from 1911 until 1947 when he retired. He had been ill for several years. He was a member of the Howard County Medical Society, Indiana and American Medical Associations.

**John J. Kidder, M.D.**, who had practiced medicine at Salamonina in Jay county for 56 years died October 11 in a Fort Wayne hospital. He had been ill three weeks. Born in Jay County in 1870, Doctor Kidder was graduated from Eclectic Medical College, Cincinnati, in 1896 and immediately began the practice of medicine in Salamonina. He was a member of the Indiana State and American Medical Associations.

**Norman B. Rosenfeld, M.D.**, 40, died October 21 in Vermillion County hospital from over sedation. His death followed by three months that of his wife who was killed in an automobile accident. Doctor Rosenfeld was a native of St. Louis, a graduate of St. Louis University School of Medicine and a veteran of World War II. He had practiced in Clinton for seven years, and was a member of the Indiana State and American Medical Associations.

**John W. Iddings, M.D.**, 73, Crown Point, died October 21 in Gary Methodist hospital after a brief illness. Doctor Iddings had practiced in Crown Point and Lowell for 45 years. He was a past president of the Lake County Medical Society, had served as president of the board of health and as health commissioner in Lowell and at one time was a member of the Indiana State Board of Health. Doctor Iddings was a Lake County native, a graduate of Northwestern University Medical School and a World War I veteran. He was a member of Lake County Medical Society, the Indiana State and American Medical Associations and a member of the American College of Surgeons.



**A. Golding Chittick, M.D.**, Frankfort physician for 45 years, died October 26 in the Veterans Administration hospital, Indianapolis, after an illness of several years. He was 69 years old. Born in Burlington, Doctor Chittick was a graduate of Indiana Medical College, School of Medicine of Purdue University, Indianapolis, in 1907. He served with the rank of lieutenant-commander in World War I. A specialist in roentgenology and radiology, he was a member of the Radiological Society of North America, Inc., of the Clinton County Medical Society and the Indiana State and American Medical Associations.

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**James R. Montgomery, M.D.**, 73, died suddenly October 29 in his office in Owensville where he had practiced for 48 years. Doctor Montgomery was a graduate of the University of Illinois College of Medicine, Chicago, in 1904 and had practiced continuously in Owensville since. He was a volunteer during World War I but was not called to active service because of the acute shortage of doctors in his community. He was a staff member of the Gibson General hospital at Princeton, a member of the American Academy of General Practice and of the Indiana State and American Medical Associations.

**John H. Hare, M.D.**, 59, Evansville psychiatrist, died October 30 suddenly. He had suffered an attack of pancreatitis recently but was thought to be recovering. Doctor Hare was superintendent of the Evansville State hospital. He had been associated with the institution for many years. A 1916 graduate of the Indiana University School of Medicine Doctor Hare was certified by the American Board of Psychiatry and Neurology, was a member of the American Psychiatric Association, a member and past president of the Vanderburgh County Medical Society, and a member of the Indiana State Medical and American Medical Associations.

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**John W. Morr, M.D.**, Albion, died after a brief illness on October 25, one week before his eighty-second birthday. Born in DeKalb county, Doctor Morr was graduated in 1894 from the Fort Wayne College of Medicine and had been in the active practice of medicine for more than 55 years. He was a member of the Fifty Year club of the Indiana State Medical Association, member of Noble County Medical Society, the Tri-State Medical society and the American Medical Association.



## News Notes

### AMA's Pictorial

#### Story Off the Press

A new pamphlet—"The AMAzing Story"—prepared by the American Medical Association, gives the general public a brief summary of the ways in which the AMA serves an average American family. This booklet pictorializes the many ways the Association serves Mr. and Mrs. Joe Typical and family. The pamphlet will be distributed to all AMA members around December 1.

### Student AMA Annual

#### Meeting December 29-30

Outstanding leaders in medicine and medical education will be featured on the program of the 1952 annual session of the House of Delegates of the Student American Medical Association December 29-30 at the Sheraton Hotel, Chicago.

Dr. Walter C. Alvarez, Chicago, will speak December 30 on "The Disappearing Art of Diagnosing with the Eyes and Ears." John Van Nuys, M.D., dean, Indiana University School of Medicine, will be the principal luncheon speaker the same day, discussing "A Dean and His Problems."

Also included on the intensive two-day schedule will be a luncheon given by the Blue Shield Medical Care Plans and a buffet supper by Abbott Laboratories of North Chicago.

It is hoped that state and county medical societies will lend enthusiastic support to local chapters of the SAMA by making sure that they are represented again this year.

Dr. George M. Buehler, a graduate of the Louisville Medical College, and a recent veteran of two years' service in the navy, has begun the practice of medicine in Jeffersonville in the office of Dr. Norman Forsee, who has been called into service.

Dr. A. J. Rissinger, Milwaukee, has opened offices in Huntingburg where he will be associated with Dr. H. K. Stork in the Stork Memorial hospital. Doctor Rissinger is a graduate of the University of Illinois. He has been in practice for the last 18 years. He is a member of the American College of Surgeons.

New officers of the **Indiana Health Officers' Association** named during the annual meeting held in connection with the Indiana State Medical Association convention are: Dr. Marvin McClain, Scottsburg, president; Dr. Minor F. Miller, Evansville, vice-president; Dr. E. L. Renbarger, Marion, secretary, and Dr. Daniel G. Bernoske, Michigan City, treasurer.

The annual conference of **county medical society officers** will be held on Sunday January 11, in the Claypool hotel, Indianapolis.

Dr. Chester A. Stayton, Indianapolis, was a recent delegate to the American Cancer Society meeting in New York.

Dr. C. R. Herd, Peru, is recovering from injuries received in an automobile collision near Angola recently. Mrs. Herd was also seriously hurt in the accident.

Dr. Julian R. Kaufman has opened an office in Fort Wayne for practice limited to the treatment of asthma, hay fever and allergic skin diseases. A native of Louisville, Doctor Kaufman was graduated from the University of Louisville Medical School, interned at St. Louis County hospital, served residencies at University of Pennsylvania and University of Wisconsin hospitals. After spending three years in the Army Medical Corps during World War II he has filled several hospital staff positions and served as professor of clinical medicine at the University of Georgia Medical School.



### AMA Sports and Health Radio Series Ready

A new series of radio transcriptions dealing with sports and health subjects will be available about December 15 from the AMA's Bureau of Health Education for use by local radio stations. The programs are based upon on-the-scene interviews with Olympic winners in Helsinki, Finland, and with national champions and other outstanding sports figures in this country.

Topics cover personal aspects, athletic accomplishments, team practice and health values of sports. Among those interviewed were Bobby Brown, M.D., of the world's champion New York Yankees; Harrison Dillard, Olympic 100-meter hurdling champion, and Julius Boros, world's national golf champion.

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### Dermatologists to Meet in Chicago

The eleventh annual meeting of the American Academy of Dermatology and Syphilology which is to be held in the Palmer House, Chicago, December 6-11, offers a wide variety of special lectures and courses. Some sessions were to be held in the College of Medicine, University of Illinois, Northwestern University, and Billings hospital.

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The United States Civil Service Commission has announced a **Medical Officer examination** for filling the positions of rotating intern, psychiatric resident and general practice resident in St. Elizabeth's Hospital in Washington, D. C.

The rotating intern positions pay \$2,800 a year, psychiatric resident \$3,400 to \$4,200, and general practice resident, \$3,400 to \$3,800 a year. Education and training is required. No written test will be given. The maximum age limit is 35 years (waived for veterans).

Full information and application forms are available at most first- and second-class post offices and at the U. S. Civil Service Commission, Washington 25, D. C. Applications will be accepted until further notice by the Executive Secretary, Board of U. S. Civil Service Examiners, St. Elizabeth's Hospital, Washington 25, D. C.

The **American Diabetes Association** is offering a \$250 prize to medical students and interns, for a paper on any subject relating to diabetes. Manuscripts should be submitted before April 1, 1953 to the Editorial Offices of Diabetes, The Journal of the American Diabetes Association, 11 West 42nd Street, New York 36, New York. They will be reviewed by the Editorial Board. The award was donated by the St. Louis Diabetes Association, an affiliate of the American Diabetes Association.

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The first annual Clinical session of the **American Academy of Obstetrics and Gynecology** will be held December 15 through 17 at the Palmer House, Chicago, with six general sessions and 48 discussion groups scheduled. Dr. Carl P. Huber, Indianapolis, the retiring president of the year-old national organization, will deliver an address at the annual banquet on Tuesday evening, December 16. There are now 2,400 qualified fellows in the group.

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### Trichinosis Topic of Chicago Conference

The American Medical Association has joined with the U.S. Public Health Service, the U.S. Bureau of Animal Industry, the American Public Health Association and the American Veterinary Medical Association in sponsoring a National Conference on Trichinosis. The meeting is scheduled for December 12 at AMA Headquarters, Chicago.

It is hoped that the Conference will stimulate interest in the need for further public education of the dangers of trichinosis. Doctors Leonard W. Larson, Bismarck, and J. J. Moore, Chicago, were appointed AMA representatives by the Board of Trustees.

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The **Nineteenth Annual Meeting** of the American College of Chest Physicians will be held at Hotel New Yorker, New York City, May 28-31, 1953. Physicians who wish to present papers at the meeting are asked to submit titles and abstracts to Dr. Arthur M. Olsen, chairman, Committee on Scientific Program, American College of Chest Physicians, Mayo Clinic, Rochester, Minnesota.

### **Army Hospital Training Program Studied by Civilian Specialists**

Study that will include all of the Army's large hospitals was launched by prominent civilian specialists in medicine, surgery and psychiatry October 20 at Fitzsimons Army Hospital, Denver, Colo., according to Maj. Gen. George E. Armstrong, Army Surgeon General.

The teams were organized by Dr. Joseph M. Hayman, Jr., of Cleveland, consultant to the Surgeon General in internal medicine. Each group will evaluate the training programs set up for both interns and resident physicians and the part taken by the regular staff and consultants in training younger men.

Their studies will cover ratio of patients to intern and residents, and degree of their responsibility, the adequacy of supervision, teaching rounds and conferences, record of trainees with specialty boards, qualifications of training officers and comparison of regular staff and consultants in relation to the training program.

**Harris B. Shumacker, Jr., M.D.**, of Indianapolis has accepted appointment as one of the surgical consultants.

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### **Army Forms Helicopter Ambulance Units**

Helicopter ambulance units, designed to evacuate critically wounded patients from forward combat areas, have been authorized as an integral part of the organization of the Army Medical Service in the theater of operations, the Department of the Army has announced.

Helicopters have been used since early in the Korean conflict to rush severely injured soldiers from battalion aid stations or regimental collecting stations to mobile Army surgical hospitals and rear-area evacuation hospitals, but they have

not previously been incorporated in formal Medical Service field-type units.

The new units will supplement rather than replace conventional means of evacuation, including litter jeeps and ambulances. All patients except those requiring emergency surgery or other definitive care will continue to be evacuated in vehicles where ground evacuation is feasible.

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**Dr. H. Paul Miller**, Fort Wayne, **Dr. Loren Ake**, Richmond, **Dr. John P. Turner**, Goshen, and **Dr. Ray Fleetwood**, Elkhart, are all attending postgraduate courses at Cook County Graduate School of Medicine.

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### **Rehabilitation Conference Planned for December 4-5**

The first statewide Rehabilitation Conference, sponsored by the Indiana Planning Committee on Rehabilitation, was to be held on December 4 in the Indiana State Board of Health Auditorium and on December 5 in the Veterans Administration hospital, Indianapolis. Ort L. Walter, State Division of Vocational Rehabilitation, acted as chairman and Emet C. Talley, Employment Security Division, was to be secretary. Other members of the committee are: Ben Edwards, State Board of Health; James A. Waggener, Indiana State Medical Association; Frederic Weigle and Chester D. Kelly, Indiana T.B. Association; Carl F. King, Marion County Department of Public Welfare; Dr. Frank M. Hall, State Department of Public Welfare; Dr. Herbert Kent, chief of Physical Medicine and Rehabilitation, Veterans Administration hospital, and E. Nancy Scramlin, representing the State Nurses Association.

Chairmen of the three sessions scheduled were to be Dr. Frank Hall; Mr. Weigle, and Dr. Herbert Kent. Representatives of both private and state welfare agencies were to participate.



**A.M.A. WASHINGTON OFFICE NEWS****Magnuson Commission Report  
Will Be Issued in Five Volumes**

The President's Commission on the Health Needs of the Nation (Dr. Magnuson) has decided to issue its report in five volumes. The study, now being written by Commission members and staff personnel, is scheduled to reach the White House by December 29. The first volume, according to a Commission spokesman, will include all major findings and recommendations. Of the remaining four, one will cover panel discussions and another will summarize the eight regional meetings conducted by the Commission during the summer. Two others will be devoted to statistics, one of them exclusively to data on the financing of medical care.

A Commission official explained that the report will be prepared in the following manner: Material in the last four volumes, statistical and background in nature, will be assembled, written and edited by some panel participants, the commissioners and staff members as a teamwork operation. Most information will come from testimony at Commission or panel sessions, but additional facts will be brought in where necessary.

The Commission itself does not expect to do the actual writing of the important first volume, the findings and recommendations. This will be prepared by the staff, based on discussions and conclusions reached verbally at meetings of the full Commission. The Commission official said this work will be "strictly policed" to insure that the final product represents Commission and not staff conclusions.

To block out the work of preparing the report, the full Commission already has met for four days in Washington. A three-day session is scheduled for November 10, 11 and 12. At least two and probably more such meetings will be held prior to release of the report.

**Typhoid Trend Reversed:  
Indiana Shows No Change**

Reversing a trend of the last decade, typhoid fever cases are showing an increase over the totals for 1951. The figures are 2,070 cases so far this year compared with 1,830 last. Public Health Service, releasing the information, comments that "present indications are that the total for 1952 will exceed that for 1951 and possibly that for 1950." Eighteen states reported increases over 1951 totals for the first 42 weeks of this year, five of them indicating 65 to 118% higher percentages.

**Addendum:** The Indiana State Board of Health reports that Indiana statistics fail to reveal any trend toward an increased number of typhoid fever cases.

Yearly totals from 1942 through 1951 are as follows: 1942, 100 cases; 1943, 92 cases; 1944, 317 cases; 1945, 82 cases; 1946, 96 cases; 1947, 108 cases; 1949, 47 cases; 1950, 49 cases; 1951, 33 cases. In the first 10 months of 1952 the Indiana State Board of Health has received reports of 31 cases of typhoid fever with the disease concentrated in 20 of the state's 92 counties, according to Dr. James W. Jackson, of the Communicable Disease division.

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**Pentagon Discussions Open  
On Doctor Draft Law Extension**

Defense Department officials with the assistance of representatives from other federal departments and professional associations, have started work on problems of the physician-dentist-veterinarian draft, preparatory to asking for an extension and amendment of Public Law 779, scheduled to expire next June 30.

Defense Department's Armed Forces Medical Policy Council sponsored the first discussion meeting, attended by spokesmen for dentists, veterinarians, hospitals, and medical schools, as well as the American Medical Association. Represented also were the Armed Forces, Defense

Department's manpower division, Selective Service and the Rusk committee.

At the first meeting, held in the Pentagon, a Defense Department spokesman gave this outline of the problem:

1. Medical Priorities I and II will be exhausted shortly, and future requirements will have to be met from Priorities III and IV. Questionnaires are now being sent to a number of physicians in Priority III.
2. There aren't enough young men in Priority III to meet military requirements for long; unless the younger men in Priority IV are made available by a change in the law, the services will be offered too many of colonel and major age and experience, not enough for the captain and lieutenant commissions. Dislocating physicians of 15 to 20 years experience from their civilian practice will create additional problems.
3. The age and experience level of Priority IV men make many of them more acceptable, but it is possible that a high percentage already have had two or more years of active military duty; besides, these men can't be called until Priority III has been used up.
4. The professional manpower shortage will continue until 1958, when enough non-veterans, currently deferred from the regular draft to complete their medical training, will be available to meet most military requirements.

No conclusions were reached at the first meeting, and association representatives were not asked to pledge support for an extension of PL 779 at this time.

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#### **Senate Government Operations Committee Plans Hearing on VA**

Chairman John L. McClellan of the Senate Government Operations Committee, plans to call a hearing in mid-January on the management survey report of the Veterans Administration which is still to be made public. The \$605,000 top-to-bottom investigation on VA operations, including medical activities, was completed last

spring and recommendations by the firm of Booz, Allen & Hamilton have been studied by various VA officials. These officials have made their recommendations on the report to VA Administrator Carl Gray and release is now up to President Truman and General Gray.

Chairman McClellan has been trying since June to get a copy of the report so that the committee staff could study it and make recommendations for remedial legislation before the new Congress convenes early in January. Senator McClellan was unable to get a copy but it was decided to proceed with the January hearings regardless.

The committee staff, upon adjournment of Congress last July, initiated studies into operations of the VA, with special emphasis on hospital construction, utilization of hospital facilities and medical personnel and on the possibilities of improving the administration of the veteran's insurance program. These studies have been held up until they can be compared with the management report.

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#### **Report on Hospital Grants in Indiana**

Frank E. Wilson, M.D., Director, Division of Hospital Facilities, FSA, reports that as of October 1, 1952, no new projects had been approved for Hill-Burton grants in the state of Indiana. Status of all Hill-Burton hospital construction in the state is as follows:

Completed and in operation: 22 projects at a total cost of \$11,680,615, including federal contribution of \$3,717,372 and supplying 776 additional beds.

Under construction: 19 projects at a total cost of \$23,124,067, including federal contribution of \$10,071,858 and designed to supply 1070 additional beds.

Approved, but not yet under construction: 1 project at total cost of \$825,000, including \$412,500 federal contribution and designed to supply 50 additional beds.



## *Indiana University News Notes*

Establishment of the **George A. Ball Visiting Professorship in Surgery** at the Indiana University School of Medicine has been announced by the James Whitcomb Riley Memorial Association. Named for the prominent Muncie philanthropist, the professorship, was a recognition of his charter membership on the Riley Association's Board of Governors, his 19 years as a Trustee of Indiana University, and his contribution with other members of his family of the Ball Residence and Annex for nurses and nursing students at the University Medical Center. Announcement of the honor was made on the occasion of Mr. Ball's ninetieth birthday.

Dr. Paul C. Bucy, internationally known Chicago neurosurgeon, has accepted an invitation from the School of Medicine to be the first of a series of distinguished surgeons to fill the visiting professorship. Definite dates have not been arranged but Dean John D. VanNuys reports that Doctor Bucy will take an active part in the surgery teaching program, ward rounds and postgraduate sessions during his weeks on the campus.

In addition to serving as professor of neurology and neurosurgery at the University of Illinois, Doctor Bucy is a trustee and chief of staff at Chicago Memorial Hospital, and chairman of the AMA Section on Nervous and Mental Diseases.

The November **'Telephone Seminar'** presented from the auditorium of the School of Medicine, had Dr. Robert Garrett, Dr. William Wishard, Dr. Wendell Shullenberger, Dr. John R. Scott, and Dr. Don Howell as members of the panel discussing, 'Urinary Tract Infections'. This was the second in the third annual series of programs sponsored by the postgraduate education committees of the School of Medicine and the Indiana State Medical Association.

The 1953 series was initiated in October with a discussion of 'Disorders of the Spinal Cord' presented by Dr. Alex T. Ross, Dr. Robert Heimburger, Dr. John R. Russell, Dr. Myron Nourse and Dr. W. L. Freeman.

Dr. Edwin A. Lawrence, professor of surgery and cancer coordinator, has been honored by election as president of the Association of Cancer Coordinators, an organization of medical and dental school officials concerned with cancer teaching.

Speakers before the **Indiana University Research Club** during the fall meetings and their subjects have included: Dr. Frederic Taylor, Department of Surgery, 'Portal Tension'; Dr. Tracy Sonneborn, Department of Zoology, 'The Development of Resistance and Susceptibility of Micro-Organisms to Their Specific Antibodies'; and Dr. Sherman Minton, Jr., Department of Microbiology, 'Clinical and Therapeutic Considerations of Venomous Bites'.

Dr. Hugh E. Setterfield, president of Alpha Epsilon Delta, national pre-medical honorary fraternity, was the dinner speaker for a meeting of pre-medical students from Indiana colleges and universities, on the Bloomington campus, last month.

Dean John D. Van Nuys, Dr. L. T. Meiks, chairman of the Department of Pediatrics and Dr. E. A. Lawrence, cancer coordinator, attended the 63rd annual meeting of the Association of American Medical Colleges, at Colorado Springs. Dean VanNuys is a member of the Association's Committee on Public Information.

A number of physicians attending the Indiana State Medical Association convention in October, visited the School of Medicine and hospitals at the University Medical Center.

Forty-one Indianapolis and Marion County women completed an intensive eight-hour **training course in the care of post-polio patients**, given last month at the Medical Center under the sponsorship of the Marion County polio chapter and the Crippled Children's Division, State Department of Public Welfare. The

women are on volunteer duty in hospital wards devoted to post-polio patients.

Two additional panels are being added to the Medical Center telephone switchboard, an expansion required by the new Union-Food Service building, the Cancer Research unit and the Service building all of which are under construction.

The Medical School library was visited by approximately 100 members of the **Mid-West Regional Group** of the American Medical Library Association, during a recent meeting in Indianapolis.

The Medical Center has been designated as one of 30 stations throughout the United States for the administration of yellow fever vaccine. Yellow fever immunization is required for persons traveling in the Far East, South America and Africa. The vaccine is given on an appointment basis by the Department of Microbiology.

# INDIANA STATE BOARD OF HEALTH

## Division of Communicable Disease Control

### MONTHLY REPORT—SEPTEMBER 1952

Disease	Sept. 1952	Aug. 1952	July 1952	Sept. 1951	Sept. 1950
Chickenpox	13	4	35	20	21
Conjunctivitis	2	0	0	2	0
Infectious diarrhea	8	5	0	0	0
Encephalitis	5	5	4	5	3
Impetigo	3	0	0	4	2
Influenza	39	4	2	26	3
Infectious hepatitis	16	12	11	3	0
Malaria	1	7	3	8	0
Measles	17	18	303	24	18
Meningitis,					
Unclassified	4	7	12	5	3
Influenzal	1	0	0	0	1
Mumps	19	21	45	21	21
Pneumonia	21	14	32	14	18
Poliomyelitis	482	317	63	129	175
Rabies in animals	12	8	17	24	31
Streptococcal infection	17	16	67	30	29
Tetanus	2	2	2	0	4
Vincent's angina	1	4	1	10	0
Whooping cough	43	30	34	88	123
Trichinosis	1	0	0	0	0
Dysentary, amoebic	1	0	3	1	0
Typhoid fever	4	8	3	4	4

## Do You Plan to Move?

### Do You Plan for a New Address?

#### Please Send in the Following:

Name \_\_\_\_\_ M.D.  
(Please print)

Old Address:

Street \_\_\_\_\_

City & Zone \_\_\_\_\_

State \_\_\_\_\_

New Address:

Street \_\_\_\_\_

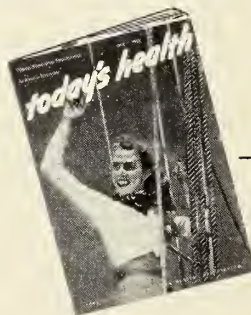
City & Zone \_\_\_\_\_

State \_\_\_\_\_

*today's health*  
a must!

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#### Physicians' Half-Price Rates

4 years	\$ 4.00
3 years	3.25
1 year	1.50

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## Society Reports

### INDIANA STATE MEDICAL ASSOCIATION

#### EXECUTIVE COMMITTEE

October 27, 1952

Roll call showed the following present: C. J. Clark, M.D., chairman; W. L. Portteus, M.D.; J. William Wright, M.D.; Paul D. Crimm, M.D.; Wemple Dodds, M.D.; Roy V. Myers, M.D.

Frank B. Ramsey, M.D., editor of *THE JOURNAL*; Albert Stump, attorney; James A. Waggener, executive secretary, and Robert J. Amick, field secretary.

#### Membership Report

Number of members October 27, 1952...3,734\*

Number of members October 27, 1951...3,629

Gain over last year ..... 105

\* Includes 77 in military service (gratis)

112 \$10 members (residents and interns)

249 senior members

1 honorary member

62 members, dues remitted by Council

#### Headquarters Office

Letter of appreciation from Mrs. Rowilson was read.

#### Annual Session, Indianapolis, October 28, 29 and 30, 1952:

Upon motion of Drs. Portteus and Dodds, approval was granted authorizing payment of hotel expenses for guests who have been invited from adjoining state medical societies.

#### Organization Matters

Dr. Crimm read a letter from the Indiana Department of the American Legion, in which a request was made for the appointment of three members of the Indiana State Medical Association to comprise a liaison committee of five, the other two representatives being one member each from the state dental and the state hospital associations, to work with a committee from the American Legion in discussing affairs affecting veterans. The Legion requested President-elect Crimm to appoint such a committee, and the following were named: Jack E. Shields, M.D., Brownstown; Dan E. Talbott, M.D., Indianapolis; Maurice E. Glock, M.D., Fort Wayne.

*Membership in National Society for Medical Research* in the amount of \$100 for the coming year was approved on motion of Drs. Crimm and Wright.

The request of Purdue University for approval

of a health program for 4-H clubs in Indiana was discussed again and no action was taken. A representative of Purdue University is to be invited to meet with the committee for discussion of this plan at its next meeting.

The invitation from the Indiana State Chamber of Commerce for representatives of the association to attend the post-election luncheon at the Murat Temple on November 18 was read. By consent it was agreed that all members of the Committee on Public Policy and Legislation and the association attorney and the executive secretary were to be asked to attend.

The announcement of the Fifth Annual Medical Public Relations Conference, to be held in Denver, December 1, was read, and by consent Dr. J. William Wright and the executive secretary were instructed to attend.

Dr. L. E. Burney, state health commissioner, appeared before the committee to explain the proposed regulation concerning the changing of the method of filing death certificates. Also discussed was the legislation proposed by the Indiana Advisory Health Council concerning the establishment and financing of full-time county health departments.

Upon motion of Drs. Wright and Portteus, membership in the Indiana State Chamber of Commerce in the amount of \$100 for the year 1953 was approved.

Upon motion of Drs. Crimm and Portteus, bills presented by the Instructional Course Committee for personnel were approved for payment.

#### The Journal

*Report on advertising* was accepted by consent:

Total, October, 1951.....	\$ 2,864.90
Total, October, 1952.....	\$ 2,910.78
10 month total, 1951.....	\$23,477.78
10 month total, 1952.....	\$22,279.32
1952 loss.....	\$ 1,197.96

#### Future Meetings

Clinical Session, American Medical Association, Denver, December 2 to 5, 1952.

National Rural Health Conference, Roanoke, Virginia, February 26, 27 and 28, 1953.

49th Annual Congress on Medical Education and Licensure, Palmer House, Chicago, February 9 and 10, 1953.

There being no further business the committee adjourned to meet again at 6:30 p.m., on Tuesday, November 18, 1952, at the Athenaeum, Indianapolis.

## The Council

(Indianapolis Session, 1952)

### First Meeting

The first meeting of the Council was held in the Harrison Room, Columbia Club, Indianapolis, at 6:30 p.m., Monday, October 27, 1952, with Dr. Wemple Dodds, the chairman, presiding. Roll call showed the following present:

#### Councilors:

First District-----Herman T. Combs, Evansville  
 Second District ----A. G. Blazey, Washington  
 Third District ----William H. Garner, New Albany  
 Fourth District ----Charles Overpeck, Greensburg  
                              George S. Row, Osgood, alternate  
 Fifth District ----M. C. Topping, Terre Haute  
                              V. Earle Wiseman, Greencastle, alternate  
 Sixth District ----W. U. Kennedy, New Castle  
 Seventh District ----Roy A. Geider, Indianapolis  
 Eighth District ----T. R. Hayes, Muncie, alternate  
 Ninth District ----Wemple Dodds, Crawfordsville  
 Tenth District ----William H. Howard, Hammond  
 Eleventh District --Elton R. Clarke, Kokomo  
 Twelfth District ----M. B. Catlett, Fort Wayne  
 Thirteenth District --Kenneth L. Olson, South Bend  
                              G. O. Larson, LaPorte, alternate

#### Officers:

J. William Wright, Indianapolis, president  
 Paul D. Crimm, Evansville, president-elect  
 Roy V. Myers, Indianapolis, treasurer  
 Frank B. Ramsey, Indianapolis, editor of THE JOURNAL

#### Executive Committee:

C. J. Clark, Indianapolis, chairman, Executive Committee  
 W. L. Portteus, Franklin, member, Executive Committee  
           James A. Waggener, executive secretary  
 Albert Stump, Indianapolis, attorney  
 Robert J. Amick, field secretary

#### Delegates and Alternates to A.M.A.:

H. G. Hamer, Indianapolis, delegate  
 F. S. Crockett, Lafayette, delegate  
 Wendell C. Stover, Boonville, delegate  
 E. S. Jones, Hammond, alternate  
 Robert H. Rang, Washington, alternate  
 Cleon A. Nafe, Indianapolis, alternate

#### Guests:

J. Neill Garber, Indianapolis, chairman, Committee on Convention Arrangements  
 James W. Denny, Indianapolis, chairman, Committee on Medical Education and Hospitals  
 L. E. Burney, Indianapolis, State Health Commissioner  
 Maurice V. Kahler, Indianapolis, chairman, Permanent Study Committee on Medical Care Insurance.

On motion of Dr. Geider, duly seconded, the minutes of the July 27, 1952, meeting of the Council, held in Indianapolis, were approved as printed in the September, 1952, JOURNAL.

### Reports of Councilors

Each councilor spoke briefly on the activities of his district.

Dr. Blazey asked for a discussion of the World Health Organization.

Dr. Hayes reported that the Eighth District Medical Society had received the resignation of

Dr. Forrest E. Keeling, councilor, as Dr. Keeling expects to be serving overseas in the Army for more than two years.

Several councilors stated that they had been unsuccessful in stimulating interest in pre-Council meetings.

*District meetings* were reported scheduled as follows:

Eighth District-----Muncie, May 13, 1953  
 Tenth District-----Whiting, November 12, 1952  
 Eleventh District-----Delphi, May 20, 1953  
 Thirteenth District----Elkhart, November 19, 1952

### Reports of Officers

*Dr. J. William Wright, president:* In the past two years I have visited every councilor district, some of them two or three times. I was very happy about the attitude that obtained in most of the places. In the past two or three weeks, three or four of us have attempted to represent the state association at several meetings. Dr. Clark and I went down to Kansas City, at the request of some men in Kansas, on this nursing situation. While nothing definite was accomplished, another meeting is to be held in January, and it is to be hoped that something will come out of this association.

We went to Detroit and appeared before the committee appointed by President Truman on the Health Needs of the Nation. We had 10 minutes to appear before the committee, of which Walter Reuther and Dr. Kenneth B. Babcock, administrator of Grace Hospital, Detroit, were chairmen. We were very well received. Fifty-two organizations were represented on that day. We felt that even though we received very short notice of this meeting, if we failed to appear we would have no right to criticize the report. It was a rather interesting experience, and whether or not a good report comes out of it, I think Indiana was represented in perfectly good faith.

Mr. Waggener and I went to Milwaukee to attend the Wisconsin meeting. We were very heartily received. If we want to promote good medicine we should promote fellowship with other states. . . . All of those things tend toward unity and the strength of our medical organization. I don't think it will do us any harm.

*Dr. Paul D. Crimm, president-elect:* I represented Bill Wright at the Kentucky State Medical Association meeting, and Art Tiernan represented Jim Waggener.

*Dr. Frank B. Ramsey, editor of THE JOURNAL:*

We are not planning any more changes in THE JOURNAL for this coming year. We have changed the type face to make it a little easier to read. There is one thing on which we would like to ask the advice of the Council. The suggestion has been made that the annual roster of members which is published in July include the home and office telephone numbers of each member, particularly with



the idea in mind when long distance calls are made in the state the telephone operator always wants to know if you have the telephone number. This is possible to do. The Indianapolis roster already carries this information, so one-third of the work is already done. The rest of the work will fall upon the county medical society secretary. It is feasible to publish these telephone numbers if the roster is to be used widely throughout the state. We would like to have the councilors consider this and give us their advice the next time they meet.

#### Unfinished Business

1. *Convention arrangements.* Dr. J. Neill Garber, chairman, reported that:

a. *Press-radio dinner* for local groups was held October 17.

b. *Trap shoot* does not attract many members and there is some question whether or not it should be a continued convention event. It has been difficult for the past few years to get someone to chairman this feature of the entertainment program.

c. Arrangements Committee expected to stay within the budget allowed by the Council.

2. *Shall House of Delegates be open to the press?* On motion of Drs. Geider and Catlett the Council voted that the House of Delegates shall be open to the press during the 103rd annual convention unless the House goes into executive session.

3. *Abolition of office of alternate councilor.* Drs. Olson, Clark, Wright, Crimm and Nafe discussed the resolution adopted by the House of Delegates on October 31, 1951, which had been printed twice in THE JOURNAL to conform with Article XIV of the Constitution, and which is scheduled for final passage by the House of Delegates at this annual session.

Dr. Olson's motion that the Council recommend to the House of Delegates that the matter of abolition of the office of alternate councilor be referred to a reference committee in the House of Delegates was duly seconded and passed.

Dr. Combs then moved that the Council recommend to the House of Delegates that the office of alternate councilor be retained. Motion seconded by Drs. Blazey and Hayes, and carried.

#### New Business

1. *American Medical Education Foundation.* Dr. James W. Denny, chairman, reported on the activities of his Committee on Medical Education and Hospitals and the results of the campaign for funds for the American Medical Education Foundation. (See report on page —, House of Delegates minutes.)

2. *Election of members of Trust Committee of Indiana Medical Education Foundation.*

Dr. Wright nominated Dr. James W. Denny.

Dr. Geider nominated Dr. Roy V. Myers.

Dr. Catlett nominated Dr. J. William Wright.

Dr. Clarke nominated Dr. Maurice V. Kahler.

Dr. Blazey nominated Dr. Roy Geider.

Dr. Garner nominated Dr. C. J. Clark.

On motion of Drs. Garner and Blazey the

nominations were closed and it was taken by consent that the above-named members were elected to serve as follows:

The first two nominated (Denny and Myers) to serve for 6 years.

The second two nominated (Wright and Kahler) to serve for 4 years.

The third two nominated (Geider and C. J. Clark) to serve for 2 years.

All appointments hereafter will be for 3 years, except where appointments are made to fill unexpired terms, and such appointments will be for the period of the term remaining at the time the vacancy is filled, in accordance with the agreement approved by the Council.

3. *Reduction in state dues.* On motion of Drs. Blazey and Hayes, the Council voted to recommend to the House of Delegates that dues be maintained at the present level.

4. *Election of JOURNAL editors.* On motion of Drs. Wright and Geider, Dr. Frank B. Ramsey, Indianapolis, was reelected editor of THE JOURNAL for 1953.

For associate editors for 1953, Dr. Combs nominated Dr. Stephen L. Johnson, Evansville; Dr. Topping nominated Dr. A. W. Cavins, Terre Haute; Dr. Hayes nominated Dr. Lall Montgomery, Muncie, and Dr. Olson nominated Dr. David A. Bickel of South Bend. On motion of Drs. Topping and Crimm the nominations were closed and it was taken by consent that those nominated were elected associate editors for 1953.

5. *Election of Editorial Board members.* Dr. Harold D. Lynch, Evansville, and Dr. Carl Culbertson, South Bend, were elected members of the Editorial Board to serve for three years, to succeed Dr. Stephen L. Johnson, Evansville, and Dr. David A. Bickel, South Bend, whose terms expire December 31, 1952.

6. *Legislative matters.* Dr. Burney discussed (a) Legislation to permit county commissioners to adopt ordinances governing health practices in their respective counties; and (b) Legislation recommended by the Indiana Advisory Health Council concerning the establishment and financing of full-time county health departments.

7. *Establishment of nurses' workshop.* Dr. Kahler explained that the Board of Trustees of the Indiana Hospital Association desired to set up a workshop for nurses in the near future and has asked that the state medical association give them some advice in this regard. On motion of Drs. Catlett and Olson the Council authorized the president of the association to appoint three members of the association to meet with the Planning Committee of the Hospital Association. Dr. Crimm appointed Drs. C. J. Clark, Maurice Kahler and Roy Geider members of this planning committee.

8. *Preceptorship resolution*, read by Dr. Kahler, was approved by the Council on motion of Drs. Combs and Garner. (See page 1292, House of Delegates minutes.)

9. *World Health Organization.* This organization was discussed by Drs. Blazey, Rang and Crimm. It was pointed out that the World Health Organization is appointed by the United Nations and should not be confused with the World Medical Association which is composed of A.M.A. representatives and medical men of other nations. The World Medical Association and the action it is taking against socialized medicine the world over is opposed to the World Health Organization. Dr. Crimm said, "As a society I don't think we should endorse the World Medical Association but as individuals we should support it."

#### Date for Midwinter Council Meeting

The Council set Sunday, January 25, 1953, as the date for the midwinter meeting.

There being no further business, the Council adjourned at 10:30 p.m., to meet again on Thursday, October 30, immediately following adjournment of the House of Delegates.

#### THE COUNCIL

(Indianapolis Session, 1952)

#### Second Meeting

The second meeting of the Council convened immediately following adjournment of the House of Delegates, Thursday morning, October 30, 1952, in the Little Auditorium at the Athenaeum, with Dr. Wemple Dodds, the chairman, presiding.

Roll call showed eight councilors, four alternate councilors, the executive secretary emeritus, the association attorney, the executive secretary and the field secretary present.

No business appearing, the Council adjourned.

#### HOUSE OF DELEGATES

(Indianapolis Session, 1952)

#### First Meeting

The House of Delegates convened in the Auditorium of the Athenaeum, Indianapolis, at 9:00 a.m., Tuesday, October 28, 1952, with the president, Dr. J. William Wright, Indianapolis, presiding.

Invocation was given by the Most Reverend Paul C. Schulte, Archbishop of Indianapolis.

On motion of Drs. George R. Daniels and Harry P. Ross, attendance slips showing 97 delegates, 4 past presidents, 4 councilors, the president, the president-elect, the editor of THE JOURNAL, the attorney, the executive secretary and the assistant secretary of the association, and 3 Student A.M.A. representatives present, were accepted in lieu of a roll call.

THE CHAIRMAN: By the authority invested in me by the Constitution of the Indiana State Medical Association, I declare the House of Delegates of the 103rd annual convention now in session.

#### In Memoriam

The House stood for a minute in tribute to the following physicians, who were members of the House of Delegates, or who had served the state association in an official capacity, and who have departed since the 1951 annual convention:

J. W. ALDRIDGE, Covington. Secretary, Fountain-Warren County Medical Society, 1921.

JOHN BIGHAM, Batesville. Delegate from Ripley County, 1936.

W. C. BUTMAN, Hebron. Delegate from Porter County, 1942.

M. JOSEPH COOMES, Shelbyville. Secretary, Ripley County Medical Society, 1908.

GEORGE W. COPELAND, Vevay. Delegate from Switzerland County Medical Society, 1934, 1936, 1937 and 1939.

JOHN M. CUNNINGHAM, Indianapolis. Member of Committee on Industrial and Civic Relations, 1921.

C. A. DeLONG, Gary. Secretary, Lake County Medical Society, 1911.

R. H. ELLIOTT, Connorsville. Secretary, Fayette County Medical Society, 1911, 1912, 1916 through 1926; member of Auditing Committee, 1946 and 1947; secretary, Fayette-Franklin County Medical Society, 1946 through 1950.

HARRY ENGLISH, Rensselaer. Delegate from Jasper-Newton County Medical Society, 1944 and 1946; secretary Jasper-Newton County Medical Society, 1925 through 1929; member of Liaison Committee of the Division of Services for Crippled Children, 1945 through 1947.

JESSE E. FERRELL, Fortville. Delegate from Hancock County Medical Society, 1936 through 1944; member of Postgraduate Study, State Fair, Medical Relief, Budget, Medical Service and Public Relations, Establishment of Board of Certification for the General Practice of Medicine, Inter-Professional Health, Rural Health and Auditing Committees; alternate delegate to the A.M.A., and president of the Indiana State Medical Association in 1946.

FRED W. GRAYSTON, Huntington. Delegate from Huntington County Medical Society, 1937.



- W. L. GROSSMAN, North Vernon. Secretary of Jennings County Medical Society, 1911 and 1912; delegate from Jennings County, 1935.
- L. D. HOLLIDAY, Fairmount. Delegate from Grant County Medical Society, 1936, 1937, 1938 and 1943.
- J. W. IDDINGS, Crown Point. Member of Study Committee on Aid to Needy Physicians, 1942; member of Centennial Celebration Committee, 1945, 1946 and 1947; member of Committee on Establishment of Board of Certification for the General Practice of Medicine, 1946.
- D. E. MAVITY, Fowler. Secretary Benton County Medical Society, 1935.
- J. E. McMEEL, South Bend. Member of Committee on Study of High School Athletics, 1937, through 1944; secretary 1940, vice-chairman 1941 and chairman 1942, Section on Medicine.
- A. G. MOORE, Camden and Indianapolis. Member of Committee on Medical Education and Hospitals, 1937 and 1938.
- ROBERT M. MOORE, Indianapolis.
- OTIS B. NESBIT, Gary. Councilor from Tenth District, 1914 through 1917; Chairman of Committee on Public Health and Instruction, 1914 through 1916; member of Centennial Celebration Committee, 1945, 1946 and 1947.
- J. S. NIBLICK, East Chicago. Member of Committee on Public Policy and Legislation, 1942, 1943, 1945 and 1950.
- HARRISON C. RAGSDALE, Bedford. Delegate from Lawrence County Medical Society, 1938; councilor from Third District, 1932 through 1937; secretary Lawrence County Medical Society, 1923 and 1924; Vice-chairman 1933 and chairman 1934, Surgical Section.
- JOHN RANES, Mt. Vernon. Secretary of Posey County Medical Society, 1920 through 1925, 1931, 1944, 1945 and 1946; delegate from Posey County Medical Society, 1938, 1939, 1944 and 1945.
- D. C. RIDENOUR, Peru. Secretary, Miami County Medical Society, 1908.
- N. B. ROSENFELD, Clinton. Secretary, Parke-Vermillion County Medical Society, 1952.
- LOUIS SANDOZ, South Bend. Member, Committee on Venereal Disease, 1947.
- CLARENCE SCHULZ, LaGrange. Delegate from La Grange County Medical Society, 1950.
- ROY E. SHANKS, Rushville. Secretary, Rush County Medical Society, 1930 through 1933; chairman of Committee on Physical Therapy, 1945; member of Committee on Crippled Children Services and Infantile Paralysis, 1949.
- BRADFORD WARREN, Marshall. Secretary Parke-Vermillion County Medical Society, 1920, 1921 and 1922.
- I. A. WHITLACH, Milan. Secretary Ripley County Medical Society, 1915, 1916 and 1922.
- GEORGE WIGGINS, New Castle. Secretary Henry County Medical Society, 1934, 1935, 1936 and 1939.
- J. RUDOLPH YUNG, Terre Haute. Member Committee on Arrangements, 1907 and 1908; member Committee on Control of Cancer, 1944.

(On motion of Dr. James M. Kirtley, duly seconded, the minutes of the interim meeting of the House, April 27, 1952, were approved as published in the June, 1952, JOURNAL.)

The following guests were introduced and extended greetings from their respective organiza-

tions to the House of Delegates and the Indiana State Medical Association:

- MARVIN M. COBLE, D.V.M., president, Indiana Veterinary Medical Association.
- JOHN K. CHAPPELL, Department Commander, The American Legion.
- JAMES R. BUTTERS, Department Service Commander, Veterans of Foreign Wars.
- E. J. SHEA, president, Indiana Hospital Association.
- HELEN J. WEBER, R.N., president, Indiana State Nurses' Association.
- A. GLENN SHOPTAUGH, Jr., president, KENNETH J. RUDOLPH and CHARLES L. MILLER, members, Indiana Student A.M.A.

MRS. HUBERT T. GOODMAN, president of the Woman's Auxiliary to the Indiana State Medical Association, presented the following report which was referred to the Reference Committee on Reports of Officers:

"Doctor Wright, members of the House of Delegates of the Indiana State Medical Association and guests:

"The Auxiliary desires to express to you, on this occasion, its sincere appreciation for this signal honor of inviting the President of your Auxiliary to appear before you. We consider this the greatest tribute of our 25-year history, which we are celebrating this year.

"Your evidence of appreciation of your Auxiliary, manifested by the growing number of jobs you have asked us to assist you in carrying on, has done more to encourage us, your wives, mothers, and daughters, to work harder to assist you in one of your most important fields of endeavor today, that of public relations.

"I would like to, but shall not impose upon your generosity, give you a detailed accounting of the many ways we have been working to be of assistance to you. We are sure you are well aware of most of them.

"If I may, I would, however, like to tell you that we have a goal for the year of completely organizing every county in the state with an auxiliary. Today, we have but 14 counties that do not have an auxiliary, or that are not organized jointly with an adjoining county. We hope by the end of this year we will see every county with an organization; we hope Indiana will be the first state to report 100 per cent organization. To do this we seek your help and assistance. As you know we cannot organize a county that has not first had the approval of the county medical society. Those of you here today, who are from counties not having an auxiliary, can be of tremendous assistance to us if you will but approve the organization of an auxiliary. It is then up to your organization to convince those in your county who are eligible that an auxiliary in their community can be an important asset to the medical profession and its program. We have the time, we are interested, we want to help you in any way we can—we work only where you want us to, and do only the work you specify and guide us in doing. We hope you will help us in our organization work.

"Thank you for this courtesy of inviting me here, and I convey to you the sincere thanks of your Auxiliary for your recognition. Thank you."

## 1952 Reference Committees

THE CHAIRMAN: In accordance with the By-laws, I have appointed reference committees, and the names of the members of these committees were published in the October JOURNAL and in the Handbook. These reference committees are to serve during this convention only and *should not be confused with the all-year round standing committees.*

To these reference committees will be referred all reports, resolutions, and measures presented to the House of Delegates at this session, except such matters as properly come before the Council. The recommendations of these committees shall be submitted at the last meeting of the House of Delegates at 7:30 a.m., Thursday, October 30, for acceptance in the original or modified form, or for rejection.

Each committee consists of five members, the first member named to be chairman of the committee. Meeting rooms have already been assigned. Will the committee members please stand as their names are called?

## 1. Sections and Section Work:

Richard P. Good, Kokomo (Howard), Chairman  
Clay A. Ball, Muncie (Delaware-Blackford)  
Truman E. Caylor, Bluffton (Wells)  
E. B. Jewell, Logansport (Cass)  
G. M. Nie, Huntington (Huntington)

## 2. Rules and Order of Business:

Lowell F. Beggs, Columbus (Bartholomew-Brown), Chairman  
A. E. Stinson, Rochester (Fulton)  
William C. Wright, Fort Wayne (Allen)  
Joel T. Carney, Jeffersonville (Clark)  
Frank Beardsley, Frankfort (Clinton)

## 3. Medical Education and Hospitals:

James W. Denny, Indianapolis (Marion), Chairman  
Elmer C. Singer, Fort Wayne (Allen)  
D. D. Stiver, South Bend (St. Joseph)  
Donald G. Mason, Angola (Steuben)  
Floyd S. Napper, Scottsburg (Scott)

## 4. Public Policy and Legislation:

Ralph Everly, Indianapolis (Marion), Chairman  
Paul A. Garber, South Whitley (Whitley)  
W. C. Stover, Boonville (Warriek)  
Arthur J. Steffen, Wabash (Wabash)  
Minor Miller, Evansville (Vanderburgh)

## 5. Publicity:

G. B. Wilder, Anderson (Madison), Chairman  
Hubert T. Goodman, Terre Haute (Vigo)  
N. A. Hibner, Monticello (White)  
Clifford H. Jinks, Indianapolis (Marion)  
Max Long, Marion (Grant)

## 6. Hygiene and Public Health:

J. M. Kirtley, Crawfordsville (Montgomery), Chairman  
A. A. Thompson, Tyner (Marshall)  
Paul R. Tindall, Shelbyville (Shelby)  
Robert O. Zink, Madison (Jefferson-Switzerland)  
Jack E. Shields, Brownstown (Jackson)

## 7. Amendments to Constitution and By-Laws:

Claude S. Black, Warren (Huntington), Chairman  
Harry P. Ross, Richmond (Wayne-Union)  
S. D. Malouf, Peru (Miami)  
D. S. Megenhardt, Indianapolis (Marion)  
Paul N. Casebeer, Clinton (Parke-Vermillion)

## 8. Reports of Officers:

G. O. Larson, LaPorte (LaPorte), Chairman  
F. R. N. Carter, South Bend (St. Joseph)  
John M. Paris, New Albany (Floyd)  
Floyd A. Boyer, Indianapolis (Marion)  
V. L. Turley, Fowler (Benton)

## 9. Committee on Credentials:

William E. Amy, Corydon (Harrison-Crawford)  
O. T. Scamahorn, Pittsboro (Hendricks)  
O. A. Province, Franklin (Johnson)  
Lester D. Bibler, Indianapolis (Marion)  
Guy B. Ingwell, Knox (Starke)

## 10. Committee on Miscellaneous Business:

William C. Reed, Bloomington (Owen-Monroe), Chairman  
John S. Hash, Noblesville (Hamilton)  
Earl W. Mericle, Indianapolis (Marion)  
Raymond Calvert, Lafayette (Tippecanoe)  
George S. Row, Osgood (Ripley)

## 11. Committee on Prepaid Medical Insurance:

Maurice V. Kahler, Indianapolis (Marion), Chairman  
C. F. Briggs, Sullivan (Sullivan)  
W. M. Stout, New Castle (Henry)  
John Woner, Linton (Greene)  
S. T. Miller, Elkhart (Elkhart)

## Report of Officers

At this time Dr. F. S. Crockett, Lafayette, presented his resignation as delegate to the American Medical Association.

THE CHAIRMAN: Reports of the officers, except for the address from the chair and the address of the president-elect, are printed in the October JOURNAL and in the Handbook, but each officer will receive five minutes to make any additions to or explanation of the reports already published.

The address of the president, to be given Wednesday evening, will be referred to the Reference Committee on Reports of Officers.

## Address of President-elect

DR. PAUL D. CRIMM, gave the following address, which was referred to the Reference Committee on Reports of Officers:

Dr. Wright, Members of the House of Delegates, Fellow Members of the I.S.M.A.:

The 1952-53 organization of the Indiana State Medical Association becomes official this coming Thursday, October 30th and a list of committee appointments will be printed in the November issue of THE JOURNAL of the Indiana State Medical Association. Many physicians are capable, but obviously few can be selected to function on the various state committees. If I made any mistakes, they were made inadvertently and with the idea of passing the jobs around. However, you will



find large committees, whose membership is distributed over the entire State of Indiana. It is disappointing that every member of the State Association cannot be assigned to "do a job" each year. Your enthusiasm and interest would be directly proportional to ergs of work demanded by each assignment. Since this is impossible you, as an individual member, can demonstrate your loyalty by attending each meeting of your county society. You can resolve to become a vital force in its arbitrations and activities. Complacency is a symptom of inertia, a disease characteristic of too many of our members of organized medicine. If your district council has inertia and because of it does not visit your county medical society at least once a year, or attend council meetings of the State Association regularly, then elect a new councilor. Brotherly love should not replace efficiency if you desire representation with your taxation. At the same time remember that the Indiana State Medical Association is not a hierarchy and your officials are not dictators, but it may seem so to you if you do not attend meetings, become active and get the lead out of your *gluteus maximus*. Gentlemen, we must work and work and work to keep the skeleton of socialized medicine locked behind the door of competition. It is sad but a true commentary on our United States that in a free America eternal vigilance is still the price we must pay for the privilege of conducting a free enterprise.

A meeting of all the committee chairmen will be held at the Hotel Lincoln Thursday noon, October 30th, in order that committee work may function immediately. From you, who have been appointed chairmen of various committees and have accepted said responsibility, we would appreciate a committee report by December 20, 1952. If the members of your committee fail to show up when you call a meeting, find out if they desire a replacement. Likewise, we will need volunteers for special committees which future necessities may demand. If you desire to work on a committee let us know who you are and what you desire to do. If any of you decide that certain committees have outlived their usefulness on said assignment, then report a good reason for discontinuing said committee. It is not good business to carry on committees if they fail to function or are loaded with worn out objectives. Committees should study their objectives in the light of revaluation, and perhaps a re-orientation of these objectives may be forthcoming.

As always, your Executive Committee, your Council, and I know this House of Delegates, stand ready to consider not only county medical society problems, but the problems of any and all members of this great medical association in the great State of Indiana. One year hence if we fail to accomplish our objectives we trust you can say, "at least they gave it the old college try."

This next year special emphasis will be directed in behalf of Medical Ethics. Hippocrates, that famous Greek physician, gave us an oath, and a law which have been the basis and guide for the ethics of the medical profession since five centuries before Christ, and

"Your officials heartily agree  
In Nineteen Hundred and Fifty-three  
To promote—constantly, not occasionally  
Medical Ethics."

Reports of the executive secretary, the treasurer, the chairman of the Council, and the councilors, were referred to the Reference Committee on Reports of Officers.

*Supplementary report of chairman of the Council.* DR. DODDS:

The Council at its meeting Monday evening, took action on three items which they desired I present to you this morning for your consideration and action.

(1) *Amendment to the Constitution Abolishing the office of Alternate Councilor*, as printed on page 19 of the Handbook. (\*Did not pass.)

(\*—) Indicates action taken. For full details, see minutes of second meeting of House of Delegates

This resolution was introduced into the House during the 1951 annual session, and was adopted at that time. Under the provisions of the Constitution, a change in the Constitution may be made only after the proposed change has laid on the table for a period of one year, and notice of the proposed change has been published in THE JOURNAL of the Association two times during the year.

This proposed amendment came up for discussion before the Council and it was the consensus of opinion that this office should not be abolished. There are occasions when a regular councilor is not able to attend a council meeting, where an alternate is available to speak for his respective district. Also, it is the feeling that more of our members should become aware of the operation of our association, and the alternate councilor setup allows each district to have two men represent them in Council meetings and such an arrangement could serve as a training program in case a district suddenly finds itself without a councilor for some reason or other.

By unanimous action of the Council therefore it was voted that the Council should recommend to this House that this proposed change in the Constitution, which under the Rules is now ready for a final vote of this House, be referred to the Reference Committee on Constitution and By-laws, in order that the membership may again have an opportunity to express its views on this matter before final action is taken, and that we further recommend that the office be not abolished.

Mr. President, I move you the adoption of this request of the Council.

(Referred to the Reference Committee on Amendments to Constitution and By-Laws.)

(2) *Resolution Concerning the Reduction of Dues of the Indiana State Medical Association*, as printed on page 23 of the handbook. (\*did not pass)

This resolution was discussed by your Council, and it is the feeling of the Council, which is your Board of Trustees, and as such are held responsible for the property of the association, as well as the finances of your organization, that a reduction in dues would be unwise at this time.

There are many reasons for our recommendation. To name just a few: we feel it would be a good policy for the Association to strengthen its financial position; expenses of operating your organization have increased — supplies, labor, and fixed charges have all shown an increase; we plan to increase our field service which will entail added expense. Our experience with having a representative of our organization in the field working constantly with our members and our component societies has proven most successful, and has met with approval of those who have had this service at their disposal. Therefore, we feel it should be expanded so we may have closer liaison with our entire membership. We do not know what we are to be faced with in the field of legislation during the coming year. We are sure all of you will agree the issue of socialized medicine is far from being a dead issue. Also to be considered is the fact that our headquarters office is becoming cramped and the Council may be faced with the problem of increasing our headquarters facilities.

Therefore the Council recommends that the present dues of the association be maintained at the same level for the coming year.

(Referred to Reference Committee on Miscellaneous Business.)

(3) *Resolution Concerning the Establishment of Preceptorships*, which was approved by the Council: (\*Adopted)

WHEREAS, The Rural Health Committee of this Association has in the past advocated the establishment of a system of preceptorships for the purpose of encouraging young physicians to become interested in general practice in rural communities; and

WHEREAS, This House of Delegates approved this recommendation made in the report of this Committee; and

WHEREAS, the system of preceptorships is being utilized with success in many other states; and

WHEREAS, interest in establishing preceptorships between general practitioners and medical students has been manifested by Indiana University School of Medicine and a number of general practitioners who are members of the Indiana State Medical Association; and

WHEREAS, the purpose of such a program is to better acquaint the medical student with the general practice of medicine; and

WHEREAS, it is a matter of concern to a number of the members of the Association that a large majority of

young physicians go into specialty training following their internships, inasmuch as the majority of these with specialty training will locate in larger cities the time will come when there will be a definite shortage of physicians in the less populated areas of our state, Now Therefore

BE IT RESOLVED: That the president of the Indiana State Medical Association appoint a committee on preceptorships for study and cooperation with the Indiana University School of Medicine. It is suggested that 50 percent or more of the committee be general practitioners.

MAURICE D. KAHLER, *Chairman*,  
Marion County Delegates.

(Referred to Reference Committee on Medical Education and Hospitals.)

#### REPORTS OF STANDING & SPECIAL COMMITTEES

**THE CHAIRMAN:** These reports are printed in the October JOURNAL and in the Handbook, but each chairman will receive five minutes in which to make any additions to the reports already published, if he so desires.

*Executive Committee*—Referred to Reference Committee on Reports of Officers.

*Board of Appeals on Patient-Physician Relations*—Referred to Reference Committee on Public Policy and Legislation.

*Conference of County Medical Society Officers*—Referred to Reference Committee on Miscellaneous Business.

*Constitution and By-Laws*—Referred to Reference Committee on Amendments to Constitution and By-laws.

*Convention Arrangements*—Referred to Reference Committee on Miscellaneous Business.

*Industrial Health*—Referred to Reference Committee on Hygiene and Public Health.

*Medical Education and Hospitals*—Dr. James W. Denny, chairman, presented the report of the committee as contained in the Handbook, and the following supplementary report, which were referred to the Reference Committee on Medical Education and Hospitals:

Mr. Chairman:

I will take but a few minutes of your time to bring you up to date on our committee. You have all had a chance to read our report in the October issue of our State Journal and are no doubt familiar with the committee report therein. I wish to discuss our work in the following order:

(1) **Telephone Seminars.** We realize this may not be the final answer to disseminate medical knowledge to the sparsely settled communities yet to date it is the best and is being copied by several other states. Your committee will meet today to outline a two year scientific program and endeavor to correct the mistakes we have made in the past. These mistakes have been the result of pioneering



and I believe we can overcome them with time and experience. We ask the participants to continue the same loyal support they have been giving.

(2) Recorded Programs: We would call your attention to the fact that Indiana has pioneered in this field and is now being followed by other states. We persuaded the A.M.A. to permit us to make recordings of the scientific program at the National Assembly last June and to make these recordings available to our membership. This is the first time scientific papers given at the A.M.A. have ever been recorded; but because of our efforts the A.M.A. will record future scientific papers read before the assembly and make them available to the various states for distribution as they see fit. I think we can all be justly proud of this accomplishment.

(3) Medical Education Foundation: As you will recall one year ago our committee set a goal of \$100,000 for the first year and the Delegates to the assembly pledged \$8,000 at our luncheon meeting. This was very generous of you and on behalf of my committee I want to thank you and at the same time ask your continued support in this worthy cause.

As of Oct. 23, 1952 we have received \$59,711.79 in cash, total number of physicians contributing 971; total Medical Societies contributing 6; total money pledged over 3-year period \$95,087.54.

While we did not reach our goal of \$100,000, we came much nearer than most of us had hoped. I am asking our committee to set a goal of \$50,000 for 1953.

(a) As you all know we established a trust fund agreement with the Indiana University School of Medicine and we have received from the National Foundation a check for 1952 for \$37,462.97 which is being held pending the selection of a proper committee by both parties. Then and then only, I can assure you, will it be wisely spent.

(b) The Trust Fund is now prepared to accept memorial gifts from individuals who wish to honor the deceased in some manner other than the conventional floral tribute. All such gifts will be properly acknowledged by a note of appreciation to the donor and a notice of receipt to the immediate survivor of the deceased.

(c) Looking to the future it is my opinion that we should this year give some serious thought to the idea of seeing that a committee be formed to invite Indiana industrialists to participate in the annual campaign for funds. All walks of life should have a deep interest in our medical education and should be informed of our efforts in this field.

As chairman speaking for our committee, I want to thank the officers and delegates of our Association for their help during the past year. We feel Jim Waggener should especially be named for his

efforts in our activities. He has given us much sound advice and guidance in our work.

*Public Policy and Legislation* — Referred to Reference Committee on Public Policy and Legislation.

*Public Relations*—Referred to Reference Committee on Public Policy and Legislation.

*Publicity*—Referred to Reference Committee on Publicity.

*Rural Health*—Dr. Louis E. How, chairman, presented the report of the committee as printed in the Handbook and the following supplementary report, which were referred to the Reference Committee on Public Policy and Legislation:

At the time that the Rural Health Committee submitted its annual report, it was stated in paragraph six (6) that a subcommittee was working on plans for a State Health Council to be submitted to this body, but that the plans were not at that time complete.

In 1950 it was agreed in the House of Delegates that such a Health Council or Foundation should be established to encourage the development of county units; to assist in the developing of the activities of already established health councils; to assist in planning and programming for Health Councils; to serve as a clearing house on health questions; to organize a state-wide Rural Health Conference; and to participate in all health activities which might come within the scope of such State Health Council.

They tentatively appropriated funds to be used for the financing of such an organization, provided that these funds could be matched by other interested groups.

In 1951 at the annual convention, we presented a proposed organizational plan based upon the approval of the previous convention. However, the convention of 1951 considered it too large a project for us to embark upon at this time.

Since there are at least three other organizations at the state level with health programs which include the formation of local health councils it is still the opinion of the Rural Health Committee that if the Indiana State Medical Association wishes to maintain its leadership in state health matters that it should again consider the formation of a State Health Council in which the Association would actively participate.

With this end in mind, a sub-committee consisting of Dr. Eli Goodman, Dr. John Bretz and Dr. M. L. Habegger have prepared a plan in which the field secretaries of the ISMA working with representatives of the Blue Cross and the Blue Shield and later including other state organizations with state health programs should be set up.

This proposed plan would anticipate that interested organizations would supply clerical assistance and make use of their own field representatives. This type of organization would be much simpler

but less expensive. But we believe that it would supply the nucleus for a state organization in which we would have our fair share of administrative control, and give us the opportunity to assist in the planning of health programs from the state down to the county level.

We submit the above recommendations for your serious consideration.

*Scientific Exhibits*—Referred to Reference Committee on Sections and Section Work.

*Scientific Work*—Referred to Reference Committee on Sections and Section Work.

*Alcoholics Study*—Dr. Louis W. Nie, chairman, presented the report of the committee as printed in the Handbook and the following supplementary report, which were referred to the Reference Committee on Public Policy and Legislation:

Following are some additional comments with reference to the Alcoholic Study Committee:

After submission of the original "no-action" report of the State Alcoholic Study Committee Dr. Lowell Beggs asked Mr. Albert Stump to prepare "A Bill for an Act Concerning Alcoholics and Drug Addicts."

A copy of this proposed bill was received by your committee's chairman on October 20, 1952, too late for all members of the committee to see this proposed legislation. However, telephone discussions with the members of the committee have produced some comments and remarks which are shared by the majority of the committee.

There is strong opposition within this committee toward *isolated* legislation pertaining to alcoholics and drug addicts. It is further felt that such legislation should be studied by the Committee on Mental Health since the symptom complexes of alcoholism and drug addiction are certainly psychiatric disorders.

Though time has not permitted a full study of the proposed act there are many proposals which should be studied and given further consideration. The majority of this committee are opposed to supporting this legislative proposal and suggest its referral to the standing committee on Mental Health. This latter committee has made in its report recommendations for the revision of mental laws and such efforts should include desirable legislation pertaining to alcoholism and drug addiction.

*Auditing*—Referred to Reference Committee on Reports of Officers.

*Cancer*—Referred to Reference Committee on Hygiene and Public Health.

*Chronic Illness*—Referred to Reference Committee on Hygiene and Public Health.

*Civil Defense*—Referred to Reference Committee on Miscellaneous Business.

*Crippled Children Services*—Referred to Reference Committee on Public Policy and Legislation.

*Diabetes*—Referred to Reference Committee on Hygiene and Public Health.

*Foot Hygiene*—Referred to Reference Committee on Hygiene and Public Health.

*Hard of Hearing*—Referred to Reference Committee on Hygiene and Public Health.

*Heart Disease*—Referred to Reference Committee on Hygiene and Public Health.

*Indiana A.M.A. Campaign Coordinating Committee* — Dr. Cleon A. Nafe, chairman, recommended that the Indiana A.M.A. Campaign Coordinating Committee be discontinued, inasmuch as the committee was set up with the express purpose of cooperating with the American Medical Association in its campaign against socialized medicine and as the A.M.A. has abolished the father committee. In no way, however, should this action be interpreted that the A.M.A. or the Indiana State Medical Association is discontinuing their campaign into the inroads of socialized medicine. Dr. Nafe recommended that the president appoint a committee to succeed the A.M.A. Coordinating Committee.

This supplementary report and the report printed in the Handbook were referred to the Reference Committee on Miscellaneous Business.

*Indiana Inter-Professional Health Council*—Referred to Reference Committee on Miscellaneous Business.

*Infantile Paralysis*—Referred to Reference Committee on Hygiene and Public Health.

*Instructional Courses*—Referred to Reference Committee on Sections and Section Work.

*Maternal and Child Health*—Referred to Reference Committee on Public Policy and Legislation.

*Permanent Study Committee on Medical Care Insurance*—Referred to Reference Committee on Prepaid Medical Insurance.

*Medical and Nursing School Scholarships*—Referred to Reference Committee on Medical Education and Hospitals.

*Mental Health*—Referred to Reference Committee on Hygiene and Public Health.

*Military Manpower* — Referred to Reference Committee on Miscellaneous Business.

*Committee on Necrology*—Referred to Reference Committee on Publicity.

*Physician-Hospital Relationship* — Referred to Reference Committee on Public Policy and Legislation.

*School Health and Physical Education*—Referred to Reference Committee on Hygiene and Public Health.

*State Fair*—Referred to Reference Committee on Publicity.

*Traffic Safety*—Referred to Reference Committee on Hygiene and Public Health.

*Tuberculosis*—Referred to Reference Committee on Hygiene and Public Health.



*Venereal Disease*—Referred to Reference Committee on Hygiene and Public Health.

*Veterans Affairs and Rehabilitation*—Dr. William H. Garner, chairman, presented the report of the committee as printed in the Handbook and the following supplementary report, which were referred to the Reference Committee on Miscellaneous Business:

Since preparing our report which is printed on page 114 of the Handbook there have been several matters referred to the Committee by action of the House of Delegates of the American Medical Association. The committee met on September 26 to discuss these matters and the committee feels we should make a supplemental report to this House for your consideration and advice so our Delegates to the AMA will know our attitude on the questions to come before the coming AMA session.

Due to the large volume of resolutions which have been presented to the House of Delegates of the AMA concerning the position of medicine with regard to the problem of hospital and medical benefits furnished under the Veterans program to those veterans with non-service connected disabilities, we would like to report the following as the opinion of your committee. We desire your approval or suggestions inasmuch as we have been asked to furnish the AMA with the attitude of our Association on this matter.

The committee in studying the problem of "Medical and Hospital Benefits for veterans with non-service connected disabilities" realize the many problems involved in this subject and the many interpretations which might be placed upon any comments we might make or any suggested recommendation which might be made.

First we realize and agree that a system is necessary for providing adequate care for those who have faithfully served their nation so they may be protected against the hazards of illness and the expense thereof. The question is how this can best be accomplished.

It is our impression the administration of a Veterans program, as it relates to medical care, to be administered efficiently and effectively should embrace only those whose illness is proven to be a result of their tenure of service.

The problem seems to lie with those Veterans who desire and need hospital and medical care, yet whose cause of illness does not fall within the classification of "service-connected." Also into this problem comes those whose illness is not service connected, yet whose financial ability precludes their obtaining care under the private system of hospital and medical care usually utilized by others.

Those who fall into this classification could, it appears to your committee, be adequately provided for under our existent programs for caring for such cases. This would fall under the jurisdiction of the Welfare Department or the Township Trustee with the understanding such care would

be equal to that provided in Veterans Facilities. It would seem appropriate for the Veterans Administration to intercede in their behalf in obtaining this care from this source.

The adoption of this plan would place the responsibility at the local level and thus encourage a reduction of cost of operation and thereby federal taxes.

Those cases which are not service connected and the individual is a person of private means or insured under some existent insurance program should seek his care from private sources the same as other individuals.

We recommend, therefore, this statement of your committee, or some similar statement be adopted by this House and the same be transmitted to the American Medical Association as indicating the attitude of the medical profession of Indiana concerning the care of Veterans with non-service connected disabilities.

We have also been asked to state our opinion on the question of providing hospital and medical benefits to dependents of armed forces personnel. In making a study of this phase of the problem the committee would like to make the following report:

Certainly, the dependents of those in our armed services are not only entitled to be assured of proper medical attention, should the need arise, but also it is a responsibility of the medical profession to assist in providing a program offering this security to the families of those who have been left at home while the wage earner is fighting for his country.

We feel it only proper that the medical profession prepare a program of offering a service plan for complete medical and surgical care for the dependents of armed services personnel—but only for that period of time the head of the family is engaged in active duty in the armed services plus a period of one year following discharge or return to reserve status. At such time we would recommend that a full year's premium be deducted from his severance pay.

Such a program could be established through our voluntary non-profit plans.

Payment for this protection should be the responsibility of the individual and not the government. If the individual's income would not permit payment of the cost through payroll deduction, then the government should readjust the pay scale to permit this being done.

We would recommend favor of such a plan in which the government would establish pay scales to permit the individual to pay the cost through payroll deduction, and pay a part of the cost of such a program as does private industry. We would oppose any plan through which the government would pay the total cost on a direct basis. We feel the individual should feel he is paying the cost.

We would further recommend that this Association go on record as approving that long term cases be transferred from service installations to existing veterans hospitals for care and treatment. Such a plan would permit better utilization of both types of facilities and should permit better utilization of professional personnel.

We feel our Delegates to the AMA should be advised that it is our feeling that the Tennessee resolution which we understand is to come before the House of Delegates of the Interim Session of the American Medical Association, should be carefully considered and all aspects carefully investigated. The question poses itself as to whether we want the federal government to become the nation's number one purchaser of hospital and medical care insurance.

*Journal Editor*—Referred to Reference Committee on Reports of Officers.

#### New Business

1. *Election of Indiana "General Practitioner of the Year."* The chairman of the Council announced that the screening committee appointed by the president had selected the following three physicians for consideration of the House for this award:

C. B. Goodwin, Kendallville  
William A. Holloway, Logansport  
John T. Kime, Petersburg

On ballot vote, Dr. John T. Kime, of Petersburg, was elected "General Practitioner of the Year."

2. *Resolutions introduced from the floor of the House.* It was taken by consent that all resolutions which were sent to each delegate 30 days in advance of the meeting and which were also printed in the Handbook should not be read. The chairman referred these resolutions as follows:

#### RESOLUTIONS REFERRED TO THE REFERENCE COMMITTEE ON SECTIONS AND SECTION WORK

*Resolution on Re-establishment of Special Committee on Conservation of Vision: (\*Adopted).*

To the House of Delegates, Indiana State Medical Association:

Last year, the committee for the Conservation of Vision was discontinued as a committee of the Indiana State Medical Society and was set up as part of our Indiana Academy of Ophthalmology and Otolaryngology. This arrangement has not proven satisfactory: 1. We have lost prestige of being an integral part of the State Medical Society. 2. Previously, we were one of the first states to have such a committee and would like to continue our seniority in this field.

The activities of this committee, in the past, has been to have a breakfast once a year, at which a guest speaker of note would discuss Conservation of Vision. Secondly, a Conservation of Vision issue of the State Medical Journal was encouraged annually.

Recently there has been created an Indiana Chapter of the National Society for the Prevention of Blindness and we have no official representation to coordinate our activities.

In view of these facts, we would like to petition the House of Delegates to re-establish a Committee for the Conservation of Vision.

Respectfully submitted,

Section on Ophthalmology and  
Otolaryngology  
Indiana Academy of Ophthalmology and Otolaryngology  
Robert A. Smith, M.D. (signed)  
Chairman: Robert Smith  
Will W. Holmes, M.D. (signed)  
President: W. W. Holmes  
Carl J. Rudolph, M.D. (signed)  
Vice-President: C. J. Rudolph  
Vice Chairman: T. W. Johnson  
E. W. Dyar, M.D. (signed)  
Secretary: E. W. Dyar  
John R. Swan, M.D. (signed)  
Secretary and Treasurer, J. R. Swan

#### RESOLUTIONS REFERRED TO THE REFERENCE COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

a. *DR. PAUL MERRELL, Indianapolis: Resolution on reducing number of required meetings: (\*Adopted).*

WHEREAS, there has been such an increase in the number of compulsory hospital staff and sectional meetings that dutiful attendance at these numerous meetings has become burdensome to the practicing physicians and to the hospitals themselves; and

WHEREAS, this actually works to the detriment of the patient by increasing the cost of hospitalization, and by requiring so much of the physician's time as to significantly reduce the time available for patient care,

THEREFORE BE IT RESOLVED that the Indiana delegates to the American Medical Association be instructed to earnestly petition the Association at the interim session in December to undertake early action to reduce the number of such required meetings, consistent with the best interests of the patient, the physician and the hospital.

b. *Resolutions from Marion County delegates regarding medical school: (\*Referred to study committee designated by the president).*

The following resolutions are proposed for the consideration of the House of Delegates by the Delegates of the Marion County Medical Society.

WHEREAS: 1. According to a report of a special hospital investigation committee of the Council of the Indianapolis Medical Society, first accepted by that Council and later by the 1951 House of Delegates, the I.U. Medical School has been (and still is) extending medical care on a full-pay basis to patients who might otherwise be attended by physicians in private practice. A large portion of this medical care is administered by physicians employed as full time teachers of medicine. The School deducts (in accordance with I.S.M.A. approval in 1948) the amounts of fees for such service from the salaries of the teachers rendering the service. Thus such fees are in effect collected by the School, although the patients concerned are billed as though the fees were retained by the physicians concerned. This practice, which challenges ethical judgment, places the School itself in competition with physicians in private practice.

2. The above mentioned report makes it clear that the Medical School obtains assignments of payment



from insurance companies, thus furthering encroachment upon the field of private practice.

3. The same report makes it clear that full-time teachers are not limiting their clinical work upon full-pay patients to rare and unusual cases requiring the high degree of specialization to be found only in teaching institutions. This is contrary to the agreement of 1948 with the I.S.M.A.

4. Resentment of physicians in private practice against invasion of their field by the Medical School has become widespread and damaging to the relationship which should exist between the School and the medical profession in general.

5. It is thought by the undersigned that the present fiscal status and practices of the Medical School have established it in the "socialized" practice of medicine. It is considered that the policy of the School in accepting patients referred by physicians in general practice, as shown in the aforementioned report, has had the unforeseen and unfortunate effect of increasing the competition of the School with specialists in private practice. This policy (which the House of Delegates has never approved) tends to depreciate the prestige of specialists in private practice and militates against the maintenance of a strong contingent of specialists throughout the State upon whom general practitioners have customarily relied, and should rely, for co-operation in treating the sick. Furthermore, this policy has had the unfortunate effect in many instances of permanently removing such referred patients from private medical supervision, except for night calls and treatment of minor injuries, since they are often continued indefinitely as out-patients of the school in the various clinics. Continued development of this tendency to by-pass highly qualified consultants and specialists in private practice, as well as hospitals unsupported by taxation, cannot fail to stultify private practice in general, relegating it to the rendering of only the humblest and least important services, thus leaving the public to the mercy of State controlled medicine.

6. Another adverse effect of over-extension of Medical School specialized services into the private patient area of practice is to over-emphasize the teaching of specialized techniques to the detriment of teaching the principles and practice of general medicine. Anxiety is frequently expressed that the School may turn out a disproportionate number of graduates imbued with ideas and trained in techniques which will make them reluctant to engage in general practice.

7. The fiscal status which seems to require the Medical School to compete with physicians in private practice for financially capable patients has the unfortunate effect of apparently justifying the School in a policy of encouraging the publication in the daily press of articles implying great superiority of the skills and facilities of the School as compared with those obtainable elsewhere in the State. Such immodest publicity is seriously detrimental to public morale, since it implies that all those who cannot be treated by the School's physicians are compelled to accept an inferior service. Furthermore, it is evident that physicians in private practice cannot command comparable publicity which, if they could, would be disallowed by established principles of ethics.

8. However much the policy of the Veteran's Administration is responsible, the fact remains that a recent inquiry disclosed that the Medical School full-time staff draws the lion's share of emolument for consultations and other services in some departments. As in the case of private patient services, the fees paid by the VA accrue to the advantage of the School, which is thus still further shown to be oper-

ating in competition with and to the disadvantage of physicians in private practice.

#### BE IT RESOLVED:

1. That the House of Delegates approve the acceptance by the Medical School of only those financially capable and/or insured patients who fall in the following categories:

- (a) Those referred for specialized service by physicians engaged in the private practice of the corresponding specialties.
- (b) Those referred for specialized services which are not available at the hands of specialists in private practice.
- (c) Those referred by any licensed doctor of medicine for diagnosis of rare and obscure conditions requiring facilities and skills not available in other institutions or in private practice.
- (d) Patients who are medical students or employees in any capacity of the Medical School, including members of their immediate families.

2. That the House of Delegates instruct the Executive Secretary of the I.S.M.A. to place these Resolutions in the hands of the Governor and of the Governor-elect of Indiana, and in the hands of any committee of the General Assembly concerned with legislation regulating the Medical School and/or providing for its operation; and particularly in the hands of any committee which might assist the Medical School by relieving it of any necessity, or privilege, of engaging in the public practice of private medicine.

3. That the House of Delegates establish a committee for liaison with Indiana University in matters of medical education, said committee to be constituted and instructed as follows: Each constituent Society in a city of 50,000 inhabitants or more to elect one committee member for each 50,000 inhabitants or fraction thereof; the committee to elect its own chairman who shall call meetings quarterly, or more frequently if requested by referendum vote of a majority of the committee; the committee to make inquiries and to hold hearings on matters pertinent to the subjects embraced in these Resolutions, to assist public officials with information, to grant temporary (ad interim) approval of arrangements proposed by the Medical School, and to report annually to the House of Delegates.

MAURICE V. KAHLER, M. D.,  
Chairman, Indianapolis Delegation

c. DR. RALPH EVERLY, Indianapolis: *Resolution regarding the Indiana University School of Medicine: (\*Adopted).*

At the Fall meeting of the Seventh District Medical Society held in Franklin October 22, the following motion was made and adopted in regard to the resolution which you have received previously concerned with the Indiana University School of Medicine:

"It is moved that the Seventh District Medical Society go on record as expressing opinion that the content of the resolution concerned with Indiana University School of Medicine is such that no action should be taken by the House of Delegates of the Indiana State Medical Association but that the matter be referred to a study committee appointed by the President of the Indiana State Medical Association."

**RESOLUTIONS REFERRED TO THE REFERENCE  
COMMITTEE ON PUBLIC POLICY  
AND LEGISLATION**

*a. Resolution on problem of accrediting nursing schools in Indiana: (\*Adopted).*

WHEREAS, our nation finds, during these critical days, that our hospital facilities, medical services and especially the number of nurses are in limited supply and that there is a vital need for continued local interest and support throughout every community in the State of Indiana to the end that additional well qualified young women may be encouraged to take training in State accredited Schools of Nursing; and

WHEREAS, it is important to encourage such State and community organizations to continue their program of recruiting young women for nurses training; and

WHEREAS, an important factor in so doing is the realization by parents of well qualified young women that Schools of Nursing are available at no great distance from the homes of such young women desiring to take such training; and

WHEREAS, the training programs as now developed in all our state accredited Schools of Nursing utilize most economically the available facilities and the fine professional services of the devoted doctors who give unstintingly of their time to the training and inspiration of the nurses in these schools,

Now, Therefore, Be It Resolved, by the Tippecanoe County Medical Society that the plan for the accrediting of Schools of Nursing as developed by the National Nursing Accrediting Service, and which is based upon educational minutiae applicable to certain nurses training institutions in some parts of the United States but which is wholly inapplicable to present excellent nurses training programs in other sections of the United States, is in fact hampering and handicapping the training of the necessary number of nurses to meet present needs;

And Be It Further Resolved, That the Indiana State Medical Association be and it is hereby requested to take action upon this subject matter by like resolution as hereinabove expressed and to re-examine the mentioned present plan for the accrediting of Schools of Nursing as developed by the said National Nursing Accrediting Service with the view, instead, of placing the decided emphasis in such training upon the further improvement of the present programs for training of nurses;

And Be It Further Resolved, That the Indiana State Medical Association be and it is further hereby requested to call the above subject matter to the immediate attention of the American Medical Association to the end that further effort in the direction of improvement in the training programs for Schools of Nursing be adopted only after a plan equally helpful to all sections of the United States has been concurred in and approved by the American Medical Association, the National Hospital Association and the Nurses Association;

And Be It Further, and Finally, Resolved, That the secretary of this Society be and he is hereby directed to forward, through appropriate channels, a duly certified copy of this resolution to the Indiana State Medical Association.

STATE OF INDIANA )  
 ) SS:  
TIPPECANOE COUNTY )

Before me, a notary public in and for said county and state, this day personally appeared /s/ Hugh B. McAdams who, being first duly sworn, upon his oath

deposes and says that he is the duly elected, qualified and acting secretary of Tippecanoe County Medical Society and as such has custody of the books, records and minutes of the meetings of such organization; that the attached and foregoing resolution is a full, true and complete copy of that certain resolution adopted by said Tippecanoe County Medical Society on the 9th day of September, 1952, at its meeting held on such date, all in accordance with the rules and procedure governing said Society, and that such resolution has remained unaltered until this date.

/s/ HUGH B. McADAMS, M.D.  
Secretary, Tippecanoe County  
Medical Society

Subscribed and sworn to before me this 13th day of September, 1952.

/s/ PAUL E. MYERS  
Notary Public

My commission expires February 14, 1956.

*b. A Resolution calling for the establishment of a Medical Economic Commission: (\*Adopted)*

WHEREAS, The public has complained of a shortage of Doctors in the State of Indiana; and

WHEREAS, It is the desire of the Indiana State Medical Association to give the best of medicine to the most people; and

WHEREAS, It has been shown that Indiana has a per capita Medical Doctor population commensurate with that of the United States; and

WHEREAS, The Medical Doctor shortage in our state is one of distribution rather than one of actual numbers; and

WHEREAS, Medical Students, Interns and Residents who are about to take up the practice of medicine are not acquainted with the possibilities of practice in communities and counties of the state as to medical facilities, economic conditions, living conditions, schools, entertainment, markets, social life and etc.; and

WHEREAS, All other specialized schools such as Engineering, Chemistry, Pharmacy, etc., attempt to place their graduates where they can profit and benefit most; therefore be it

Resolved, That the Indiana State Medical Association in conjunction with the Indiana University School of Medicine, local Service Clubs, Fraternal Organizations, Chambers of Commerce and Veterans Organizations establish a Commission which will be permanent and who will attempt to keep a year to year survey of needs of counties and communities in our state and present these needs to those Doctors who are ready to practice, extending to them all of our combined support in establishing practice in these communities. This Commission or Bureau to be made up of members of the Medical Profession and such lay personnel as would be pertinent to the execution of the aims of this Commission; and be it further

Resolved, That this Commission should present the facts learned, annually to the Graduating Class of the University, also to those Residents and Interns who are ready to practice, giving them a study that would include all of the phases of the Practice of Medicine, economic and social. It is felt that the adoption of this resolution and the formation of such a Commission would greatly aid in attaining the proper distribution of doctors for the people of the State of Indiana.

This Resolution respectfully submitted to the House of Delegates of the Indiana State Medical Association for their consideration.



County	Pop.	Total To				M.D.'s	
		M.D.'s	35	50-55	65+	per pop.	
Adams	21,254	22	7	8	3	4	1-966
Allen	155,084	214	26	93	51	44	1-725
Bartholomew	28,276	27	5	13	6	3	1-1047
Benton	11,117	9	3	1	1	4	1-1235
Blackford	13,783	14	2	8	1	3	1-913
Boone	22,081	27	8	6	5	8	1-818
Brown	6,189	4	1	0	1	2	1-1547
Carroll	15,410	7	1	2	0	4	1-2200
Cass	36,908	39	3	13	4	19	1-946
Clark	31,020	22	2	11	7	2	1-1410
Clay	25,635	12	2	5	1	4	1-2136
Clinton	28,411	30	7	11	6	6	1-947
Crawford	10,171	4	1	0	3	0	1-2543
Daviess	26,163	23	5	10	2	6	1-1137
Dearborn	23,053	13	1	6	1	5	1-1773
Decatur	17,722	18	1	6	2	9	1-984
DeKalb	24,756	22	3	11	5	3	1-1125
Delaware	74,963	85	25	33	15	12	1-882
Dubois	22,579	41	3	2	2	4	1-2052
Elkhart	72,634	77	12	32	16	17	1-940
Fayette	19,411	16	2	7	3	4	1-1213
Floyd	35,061	32	5	9	12	6	1-1096
Fountain	18,299	14	2	6	5	1	1-1307
Franklin	14,412	6	1	2	2	1	1-2402
Fulton	15,577	12	0	8	0	4	1-1298
Gibson	30,709	27	4	6	8	9	1-1137
Grant	55,817	44	7	19	9	9	1-1268
Greene	31,330	21	4	10	3	4	1-1492
Hamilton	24,614	9	1	3	3	2	1-2735
Hancock	17,302	17	3	7	1	6	1-1018
Harrison	17,106	7	1	2	1	3	1-2444
Hendricks	20,151	19	6	7	1	5	1-1300
Howard	47,752	44	5	12	14	13	1-1095
Huntington	29,931	23	3	7	8	5	1-1301
Jackson	26,613	18	2	7	3	6	1-1478
Jasper	14,397	9	3	3	2	1	1-1600
Jay	22,601	22	4	4	6	8	1-1047
Jefferson	19,912	20	4	6	5	5	1-995
Jennings	13,680	8	0	2	0	6	1-1410
Johnson	22,493	19	2	9	5	3	1-1183
Knox	43,973	49	10	17	12	10	1-897
Kosciusko	29,561	17	4	6	4	3	1-1738
LaGrange	14,352	7	3	2	0	2	1-2050
Lake	293,195	293	63	127	70	33	1-1000
LaPorte	63,660	64	11	28	14	11	1-994
Lawrence	35,045	25	5	10	6	4	1-1401
Madison	88,575	91	19	35	24	13	1-973
Marion	460,926	1077	363	352	184	178	1-428
Marshall	25,935	27	9	12	2	4	1-960
Martin	10,300	6	1	2	0	3	1-716
Miami	27,926	22	2	8	4	8	1-1469
Monroe	36,534	40	9	17	8	6	1-913
Montgomery	27,231	24	4	13	4	3	1-1134
Morgan	19,801	19	3	5	9	2	1-1042
Newton	10,775	7	0	5	1	1	1-1539
Noble	22,776	25	5	7	6	7	1-911
Ohio	3,782	6	0	3	0	3	1-630
Orange	17,311	12	1	6	0	5	1-1432
Owen	12,090	8	1	2	2	3	1-1511
Parke	17,358	13	0	5	4	4	1-1335
Perry	17,770	9	1	1	2	5	1-1974
Pike	17,045	10	2	1	0	7	1-1704
Porter	27,836	27	1	7	11	8	1-1031
Posey	19,183	13	1	5	1	6	1-1475
Pulaski	12,056	7	1	1	3	2	1-1722
Putnam	20,839	22	4	8	5	5	1-947
Randolph	26,766	29	5	9	11	4	1-854
Ripley	18,898	14	2	7	3	2	1-1350
Rush	18,927	11	1	6	3	1	1-1720
St. Joseph	161,823	200	34	88	55	23	1-809
Scott	8,978	4	0	3	1	0	1-2244
Shelby	25,953	23	3	7	4	9	1-1129
Spencer	16,211	6	0	2	3	1	1-2702
Starke	12,258	5	2	2	0	1	1-2451
Steuben	13,740	13	5	4	0	4	1-1057
Sullivan	27,014	18	3	5	4	6	1-1500

County	Pop.	Total To				M.D.'s	
		M.D.'s	35	50-55	65+	per pop.	
Switzerland	8,167	5	1	1	0	3	1-1639
Tippecanoe	51,020	93	24	37	17	15	1-548
Tipton	15,135	13	2	4	1	6	1-1664
Union	6,017	3	0	1	1	1	1-2002
Vand'burgh	130,783	197	30	94	45	28	1-668
Vermillion	21,287	12	0	3	3	6	1-1774
Vigo	99,709	113	16	45	20	32	1-882
Wabash	26,601	24	2	9	8	5	1-1108
Warren	9,055	3	1	2	0	0	1-3018
Warrick	19,435	11	3	3	2	3	1-1767
Washington	17,008	8	0	3	1	4	1-2126
Wayne	59,229	86	27	25	17	17	1-688
Wells	19,099	28	7	11	7	3	1-682
Whitley	17,001	17	4	3	6	4	1-1000
White	17,031	17	1	7	1	8	1-1000

c. DR. A. G. BLAZEY, Washington: *Resolution for concerted grass roots action against socialization: (\*Adopted)*

WHEREAS, the unfortunate passage of HR 7800 by the eighty-second Congress created Public Law 590; and

WHEREAS, Section 3 of P. L. 590 creates socialized medicine for disabled social security recipients and gives Oscar Ewing or his successor full power and authority to make rules and regulations, including veto power over a physician's determination of disability; and

WHEREAS, the lobbying efforts of organized medicine failed in preventing the enactment of P. L. 590 due to insufficient grass roots information concerning Section 3 of HR 7800; and

WHEREAS, the enactment of P. L. 590 has been a serious blow to organized medicine's fight against the inferior medical care that socialization would provide;

*Therefore Be It Resolved*, That the Indiana State Medical Association should institute an educational campaign directed at its individual members by appropriate action by its House of Delegates here convened, to the end that all of our membership may be informed of the dire implications of Section 3, P. L. 590, so that they may voice their objections to the next session of Congress, and so that they can pass the information along to their patients in order that they, too, may express their distaste for such socialized legislation to their representatives in Washington, for the purpose of terminating that law before June 30, 1953.

*Be It Also Resolved*, That a copy of this resolution be forwarded to the American Medical Association as an Indiana State Medical Association request for national action at the interim meeting to be held at Denver in December, 1952.

Officially adopted by the Daviess-Martin County Medical Society in regular session October 21, 1952.

J. J. FARRIS, M. D., *President*

H. R. SCHROEDER, JR., M. D., *Secretary*.

d. DR. A. G. BLAZEY, Washington: *Resolution on I. L. O.: (\*Adopted)*

WHEREAS, the latest convention of the I. L. O. would, through treaty power, force socialized medicine into this country,

WHEREAS, the universal experience of past history demonstrates the inferior care afforded by socialized medicine,

*Therefore Be It Resolved*, That the Indiana State Medical Association go on record as opposing such a clandestine effort to thwart the public opposition to known socialist measures in this nation.

*Be It Further Resolved*, That copies of this resolution be sent to all members of the Senate and House of Representatives.

**RESOLUTION REFERRED TO REFERENCE COMMITTEE ON HYGIENE AND PUBLIC HEALTH**

*Appointment of pathologist as a member of the Indiana State Board of Health: (\*Tabled)*

WHEREAS the Indiana State Board of Health consists of nine members, three of whom are physicians; and

WHEREAS the activities of the Indiana State Board of Health are concerned in large part with laboratory medicine (serology, bacteriology, etc.); and

WHEREAS among physicians, the pathologists are best qualified by training, experience and familiarity with laboratory medicine, and

WHEREAS the pathologists have not been represented on the State Board of Health for many years,

*Now, Therefore Be It Resolved*, That the Governor of the State of Indiana be petitioned by the Indiana Medical Association to give consideration to the appointment of a pathologist as a member of the Indiana State Board of Health; and

*Be It Further Resolved*, That the Indiana Association of Pathologists be permitted to submit a list of names from which this appointment would be made.

(Approved by the Tippecanoe County Medical Society)

**RESOLUTIONS REFERRED TO REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION AND BY-LAWS**

*a. Amendment to Constitution, abolishing office of Alternate Councilor: (\*Did not pass)*

At the 1951 annual session in Indianapolis the House of Delegates adopted the following resolution, which will abolish the office of alternate councilor:

"RESOLVED, That Article IX of the Constitution of the Indiana State Medical Association be amended by striking out Section 5 thereof, and by renumbering the remaining sections accordingly."

Section 5, which the above resolution deletes, reads as follows:

"Sec. 5—Each Councilor district shall elect an alternate Councilor whose term of office shall be the same as the Councilor, namely three years. The alternate Councilor shall be elected in a year during which there is no Councilor elected.

"The duties of the alternate Councilor shall be:

"1. To represent the Councilor district in the absence of the regularly elected Councilor.

"2. To vote only in the absence of the regularly elected Councilor either in the House of Delegates or in Council meetings where he represents the regularly elected Councilor.

"3. The alternate Councilor shall not have the power of discussion if the regularly elected Councilor is present."

This amendment was printed in the December, 1951, *Journal*, and is carried in the October 1952 *Journal*, to conform with Article XIV of the Constitution, which states that "The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates present at any Annual Convention, provided that such amendment shall have been presented

in open meeting at the previous Annual Convention, and that it shall have been published twice during the year in THE JOURNAL of this Association."

*b. Amendment regarding senior membership, adopted by the House of Delegates at the interim session, Indianapolis, April 27, 1952: (\*Did not pass)*

RESOLVED, That Section 4 of Article IV of the Constitution be amended to read as follows:

Sec. 4—Senior Members.—Senior members shall be physicians of the State of Indiana who have attained the age of seventy-five years and have held membership in the Indiana State Medical Association for twenty years or more; or who have held membership in the Indiana State Medical Association and in some one or more other like state organization which is a component state organization of the American Medical Association, for a combined total of twenty years or more,—and who, upon their application, and upon the recommendation of their respective county medical society have been certified to the executive secretary as eligible for such membership by their county societies of which they are members. It shall be the duty of the county medical society to verify, through the office or offices of any other such state organization or organizations, the fact of membership therein when such membership is claimed as part compliance with the eligibility requirement of twenty years of membership.

All members who, previous to the adoption of this amendment to the constitution, were certified as honorary members on the basis of the above qualifications, shall hereafter be classified as senior members.

**RESOLUTIONS REFERRED TO REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS**

*a. Resolution concerning official endorsement of activities, principles and policies of individuals and organizations: (\*Did not pass; considered unfavorably)*

WHEREAS, The I. S. M. A. and the Component County Medical Societies are meeting many requests from organizations and individuals for approval of principles, and objectives in behalf of their various endeavors, and

WHEREAS, The I. S. M. A. and the Component Medical Societies neither have the authority nor the desire to control or direct the scope of the activities of such individuals or organizations, and

WHEREAS, The I. S. M. A. and the Component County Medical Societies do have the power and authority to control and direct the official activities of the Component County Medical Societies, and through their delegates possess the power to regulate and control the official activities of the I. S. M. A. and the A. M. A.,

*Therefore, Be It Resolved*, That the I. S. M. A. and the Component County Medical Societies refrain from giving official endorsement of activities, principles and policies of individuals and organizations other than those acting in an official capacity for the Component County Medical Society, the I. S. M. A. and/or the A. M. A.,

*And Be It Further Resolved*, That nothing in this resolution be construed as prohibiting the I. S. M. A. or the Component County Medical Societies from permitting individuals or representatives of organizations to present at meetings of the I. S. M. A. or the Component County Medical Societies the scope and nature



of their activities, principles, and policies, with pro and con discussion,

*And Be It Further Resolved*, That nothing in this resolution shall be construed as restraining a member of a Component County Medical Society and the I. S. M. A. from affiliating as individuals with any such organization whose activities, principles, and policies do not conflict with the activities, principles, and policies of the I. S. M. A. and the Component County Medical Societies.

Approved by the Vanderburgh County Medical Society in a regular meeting at the Hotel McCurdy in Evansville, September 9, 1952.

*b. Resolution requesting honorary membership for Dr. Stefan Ansbacher, Marion, Indiana: (\*Adopted)*

WHEREAS, Stefan Ansbacher, formerly of New York State, holding the Doctor of Science degree from the University of Geneva, Switzerland; an Affiliate Fellowship in the American Medical Association, and an Associate Membership in the Medical Society of the State of New York and the Medical Society of the County of Queens, and an associate member of the Grant County (Indiana) Medical Society, now residing at Jocinah Farms, Marion, Indiana, and being a practicing Scientific Consultant, is a scientist who has rendered highly meritorious service to the profession of medicine, to wit: his publications on vitamin D which were editorially cited by The Journal of the American Medical Association; his work on riboflavin for which he was awarded the Billings Medal from the American Medical Association; his discovery of the most active vitamin K compound for which he received recognition from the American Medical Association; and his finding of the vitamin-nature of paraaminobenzoic acid on which The Journal of the American Medical Association commented editorially.

*Therefore, Be It Resolved*, That the Indiana State Medical Association confer on him Honorary Membership as a special honor.

Grant County Medical Society  
RUSSELL W. LAVENGOD, M.D., *Secretary*

*c. Resolution requesting reduction in State association dues: (\*Did not pass)*

In the January 15th meeting of the Clinton County Medical Society a motion was made, seconded and carried that our delegate to the Indiana State Medical Association should request a reduction of the dues to the Indiana State Medical Association. Request this action by the Clinton County Medical Society be made of record at this time for presentation before the House of Delegates at its regular meeting this fall.

Sincerely,  
C. D. HOLMES, M.D., *Secretary*

*d. DR. PAUL R. TINDALL, Shelbyville: (\*Approved)*

*Report of committee to study special medical licensure:*

Your committee to study special medical licensure, authorized at the interim meeting of the House of Delegates, April 27, 1952, met in Shelbyville, Indiana, on October 5, 1952.

This committee considered its objective to be the advancement of some legal plan to relieve the shortage of trained hospital personnel without weakening our present Medical Practice Act or in any manner limit the reciprocity/endorsement privileges of Indiana physicians.

A recommendation for new legislation was considered and rejected after it was learned that a committee of the Board of Medical Registration and Examination of Indiana, undertaking a similar study, was proposing the following ruling for adoption:

"That graduate medical students registered in hospitals licensed under the laws of the State of Indiana shall be considered as "trainees", and may study medicine, surgery, and obstetrics under the immediate and direct supervision of licensed staff members of such hospital for a period not to exceed one year; and shall not be considered as practicing medicine. Nothing in this ruling shall be construed as applying to regular internships and residencies in such hospitals."

Your committee recommends the approval of this proposed ruling and prays its adoption by the Board of Medical Registration and Examination of Indiana.

Your committee further learned that the foregoing named Board would consider a change in its "rule governing examination and licensure for graduates of schools located outside the United States and its possessions." This change would permit the foreign graduate to either repeat the senior year in an approved United States medical school or, "present documentary evidence, satisfactory to the Board of Medical Registration and Examination of Indiana, of having completed a minimum of two years of post-graduate work (subject to approval by the Board) in a hospital located in the United States, which is approved by the Council on Medical Education and Hospitals, of the American Medical Association."

Your committee recommends the approval of this ruling and prays its adoption by the Board of Medical Registration and Examination of Indiana.

PAUL R. TINDALL, M.D., *Chairman*,  
LALL G. MONTGOMERY, M.D.,  
ALBERT M. DONATO, M.D.,  
ALBERT STUMP, *Attorney*.

**RESOLUTION REFERRED TO REFERENCE COMMITTEE ON PREPAID MEDICAL INSURANCE**

*Resolution on issuance of two checks by Mutual Medical Insurance, Inc., adopted by Permanent Study Committee on Medical Care Insurance: (\*Adopted)*

WHEREAS, The Directors of Mutual Medical Insurance, Inc., requested a reconsideration of the issuance of two checks as approved by the House of Delegates, its objection being that under certain circumstances it might be a party to fee splitting; and

WHEREAS, This committee obtained correspondence from the American Medical Association and the American College of Surgeons, who favored the issuance of two checks, if desired, because in those instances when the fee was divided it became a matter of open record and as such could not be construed as aiding, abetting or becoming a party to the splitting of a fee; and

WHEREAS, Further correspondence was obtained from Blue Shield of Wisconsin and a practicing physician in Wisconsin, wherein it was stated that two

checks had been issued in Wisconsin for some four years and had proven satisfactory to the patient, the doctors and Blue Shield; and

WHEREAS, After consideration of this information the Committee reaffirmed its previous stand; and

WHEREAS, After the presentation of this information to the Council of the Indiana State Medical Association, the Council approved the action of the Committee;

Therefore Be It Resolved, That this House of Delegates reaffirm its previous action in which it approved the issuance of two checks by Mutual Medical Insurance, Inc., when desired, one to the surgeon and one to the other participating doctor.

#### INTRODUCTION OF GENERAL PRACTITIONER OF THE YEAR

DR. JOHN T. KIME, Petersburg: Members of the House of Delegates: I appreciate very much the honor you have bestowed upon me today. I have been coming here since April 1889; I joined the state medical society in that year. I don't see a single face here that I knew at that time. I have had a long, hard, strenuous row in the practice of medicine in this state, commencing in '89; and I am still doing some work. There is nothing I can say to add to your pleasure in the practice of medicine—just keep at it, and do unto others as you would like them to do unto you, and you will live longer and be happier.

No further business appearing, the House of Delegates adjourned, to meet again at 7:30 a.m., Thursday, October 30, 1952, in the Little Auditorium, Athenaeum.

#### HOUSE OF DELEGATES

(Indianapolis Session, 1952)

##### Second Meeting

The second meeting of the House of Delegates was called to order by Dr. J. William Wright, president, in the Auditorium of the Athenaeum, Indianapolis, at 8:30 a.m., Thursday, October 30, 1952.

Attendance slips, accepted in lieu of a roll call, showed 101 delegates, 2 alternate delegates, 6 past presidents, 10 councilors, the president, president-elect, 1 A.M.A. delegate, 1 A.M.A. alternate delegate, the editor of THE JOURNAL, the chairman and a member of the Executive Committee, the treasurer, the executive secretary emeritus, the executive secretary, assistant secretary and the attorney of the association, the executive secretary of the Lake County Medical Society, and 1 Student A.M.A. representative present.

#### ELECTION OF OFFICERS

Election of officers resulted as follows:

*President-elect, 1952-53* --William Harry Howard, Hammond

*Treasurer* -----Roy V. Myers, Indianapolis

*Assistant Treasurer* -----James W. Denny, Indianapolis

*A.M.A. delegate to fill*

*unexpired term of*

*Dr. F. S. Crockett,*

*Lafayette*-----Karl Ruddell, Indianapolis

Dr. Crockett again presented his resignation as delegate to the A.M.A., effective as of October 30, 1952, which was accepted on motion of Drs. Catlett and Clarke.

Dr. Karl Ruddell, Indianapolis, was elected A.M.A. delegate to fill Dr. Crockett's term which expires December 31, 1953.

Dr. H. G. Hamer, Indianapolis, A.M.A. delegate whose term expires December 31, 1952, announced that he wished to retire and did not want to stand for re-election.

On motion of Dr. Lester D. Bibler, duly seconded, the House gave a rising vote of thanks and appreciation to Dr. Crockett and Dr. Hamer for their many years of service as delegates from the Indiana State Medical Association to the American Medical Association.

*A.M.A. delegates elected*

*for term expiring De-*

*cember 31, 1954* -----

Cleon A. Nafe, Indianapolis

E. S. Jones, Hammond

*A.M.A. alternates elected*

*for term expiring De-*

*cember 31, 1954* -----

Alfred Ellison, South Bend

William C. Wright, Fort

Wayne

*A.M.A. alternate delegate*

*elected to fill term of*

*Dr. Cleon A. Nafe,*

*which expires Decem-*

*ber 31, 1953* -----

Lall G. Montgomery, Muncie

DR. W. H. HOWARD, President-elect: Mr. President and fellow delegates: I first want to thank you for this honor you have conferred upon me. I have sat down in those seats for a good many years, first as a delegate and then as a councilor. I have seen many presidents-elect brought in. They have always looked a little frightened and very humble. I can see now why they looked that way.

The responsibility of this office should not be taken lightly. There is still a great deal of work to be done if we are to keep the practice of medicine on the high plane it deserves. This work cannot be done by your officers alone but we need each and every one of you.

Again I want to thank my many friends who have made this possible for me. I cannot repay you in any way except by hard work and if I work hard enough maybe that will make up for the lack of ability that I actually have.

#### PLACE OF 1954 ANNUAL SESSION

On invitation of Dr. M. B. Catlett the House voted to hold the 1954 convention at Fort Wayne.



## REPORTS OF REFERENCE COMMITTEES

## SECTIONS AND SECTION WORK

DR. RICHARD P. GOOD, chairman, presented the following report, which was adopted section by section and as a whole, on motion of Drs. Good and Elton R. Clarke:

The Reference Committee on Sections and Section Work wishes to submit the following report:

1. *Report of Committee on Scientific Exhibits.* The scientific exhibits were examined in detail by the committee, and the committee was unanimous in its opinion that the exhibits are up to their usual high standard. The exhibitors are to be highly commended for their efforts in producing these very instructional displays.

2. *Report of Committee on Scientific Work.* The committee wishes to commend this committee for re-arranging the program this year in such a manner that there is no conflict between the House of Delegates sessions, sectional meetings and instructional courses. The new arrangement of the program affords any member the opportunity of attending all features of the convention without missing others. We believe this will be reflected this year by increased attendance at the general sessions.

The members of the various sections were enthusiastic about the re-establishment of sectional programs. The committee feels that the sectional work should again be continued during the next year's convention. The Committee on Scientific Work is to be commended for obtaining so many outstanding speakers for the general sessions.

3. *Report of Committee on Instructional Courses.* Dr. Sage and Dr. Batman and their committee are to be commended and thanked for the great amount of work that was necessary to arrange this part of the convention program. The fact that all the courses were totally filled testifies as to the popularity of the instructional courses. The committee feels that the instructional courses will expand as time goes on and will continue to be a very important feature of the state convention. The Indianapolis Medical Society is to be thanked for its fine cooperation in supplying the faculty for these courses.

4. *Resolution on re-establishing Special Committee on Conservation of Vision.* A detailed investigation of this resolution was conducted by the committee. Expressions of opinion were obtained from officers of the Indiana Academy of Ophthalmology and Otolaryngology and the officers of the Section on Ophthalmology and Otolaryngology of the state association. This committee was discontinued two years ago because of inactivity. Its only function had been the holding of a breakfast meeting at the annual convention

with a guest speaker and assisting the editor of the state JOURNAL in collecting articles for publication in the Conservation of Vision number of THE JOURNAL. Both of these activities can well be done by officers of the Section on Ophthalmology and Otolaryngology. However, within the past two years there has developed an organization within Indiana concerned with prevention of blindness. At the present, this organization is lay controlled but asks for guidance from organized medicine. With the re-establishment of this committee there would be an official group to act as liaison with this organization and help keep its activities within proper bounds. Therefore, this committee recommends to the House of Delegates the adoption of the resolution for the re-establishment of the Committee on Conservation of Vision.

RICHARD P. GOOD, M.D., *Chairman*,  
CLAY A. BALL, M.D.,  
TRUMAN E. CAYLOR, M.D.,  
E. B. JEWELL, M.D.,  
G. M. NIE, M.D.

## RULES AND ORDER OF BUSINESS

DR. LOWELL F. BEGGS, chairman, reported that no business had been referred to his committee; therefore the committee had nothing to report.

## MEDICAL EDUCATION AND HOSPITALS

DR. JAMES W. DENNY, chairman, presented the following report, which was adopted section by section and as a whole, on motion of Drs. Denny and Lester D. Bibler:

1. Your committee reviewed the report of the Committee on Medical and Nursing School Scholarships as printed in the Handbook and we recommend it be adopted. Mr. Chairman, I so move.

2. We have also reviewed the report of the Committee on Medical Education and Hospitals and will discuss it only if requested from a member of the assembly. Otherwise, Mr. Chairman, I move it be adopted.

3. We have studied the resolution concerning the Establishment of Preceptorships. Several members appeared before us to discuss this resolution and all were in favor of it, including Dean Van Nuys and two senior medical students who appeared before our committee. Dr. Van Nuys spoke at length on this subject in a very frank manner. He pointed out that for the medical school to embark upon such a program would entail a great amount of caution in the selection of the preceptor, the location of the preceptor, whether the student be paid, his length of association with the physician, his various duties with the physician. It must be realized that the student is to receive

training and not merely be a flunkey, nor should he be used to relieve the physician so that the latter in a sense could take a vacation. It was pointed out by Doctor Van Nuys that one school was announcing in its bulletin that it was now using preceptorship study, yet its ruling calls for a maximum of 11 days and a minimum of 4 days. This, in his opinion, is useless.

We believe this resolution should be adopted since we believe it has merit. At the same time we think it wise to call attention to the assembly that this resolution has to do with medical education and there is at present a permanent standing committee on such matters. However, we feel that this committee has all the work it can do and that the preceptorship committee should be appointed with the understanding that at least one member of the Medical Education and Hospital Committee and at least one member of the Rural Health Committee be made members of the Preceptorship Committee. This will furnish liaison between these kindred committees so that better work can be done. I move adoption of this resolution with the above amendment.

5. We have reviewed the Resolution on Reducing the Number of Required Meetings and move its adoption.

6. We have reviewed the Resolution from Marion County Delegates, regarding the medical school and move that no action be taken by the House of Delegates of the Indiana State Medical Association, but that the matter be referred to a study committee designated by the President.

JAMES W. DENNY, M.D., *Chairman*,  
ELMER C. SINGER, M.D.,  
D. D. STIVER, M.D.,  
DONALD G. MASON, M.D.,  
FLOYD S. NAPPER, M.D.

DR. DENNY: We do not consider this a Marion County matter; it should be on a state level. The committee is already set up by your Constitution—the Committee on Medical Education and Hospitals, and we so move. (Motion seconded by Dr. Bibler, and carried.)

#### PUBLIC POLICY AND LEGISLATION

DR. RALPH EVERLY, chairman, presented the following report, which, on motion of Dr. Everly, seconded by Dr. Bibler, was adopted:

The following resolutions were acted on and passed unanimously by the Reference Committee on Public Policy and Legislation:

1. Problem of accrediting nursing schools.
2. Establishment of Medical Economic Commission. The committee approved wholeheartedly the sentiment of this particular resolution and further moved that a sub-committee to the Rural

Health Committee be appointed by the President to further study and implement the points of this resolution.

3. A letter of information submitted by Dr. Louis Nie regarding the State Alcoholic Commission.

4. Grass roots action against socialism.

5. The committee report and the supplemental report on Rural Health. On behalf of the Indiana State Medical Association this reference committee wishes to extend a most sincere vote of thanks to the Rural Health Committee for a job very well done.

6. I. L. O. resolution.

7. The reports of the following committees were read and approved:

- a. Committee on Public Policy and Legislation.
- b. Committee on Public Relations.
- c. Board of Appeals on Physician-Patient Relations.
- d. Alcoholic Study Committee.
- e. Committee on Crippled Children Services.
- f. Committee on Maternal and Child Health.
- g. Committee on Rural Health.
- h. Committee on Physician-Hospital Relationship.

We move the adoption of all of these reports.

RALPH EVERLY, M.D., *Chairman*,  
PAUL A. GARBER, M.D.,  
W. C. STOVER, M.D.,  
ARTHUR J. STEFFEN, M.D.,  
MINOR MILLER, M.D.

#### PUBLICITY

DR. G. B. WILDER, chairman, presented the following report, which was adopted section by section, and as a whole, on motions of Dr. Wilder, duly seconded:

1. This Committee wishes to commend the Committee on Publicity for its splendid work during the year. Its health hints, general news releases, radio and TV programs and publications have all been timely and well chosen.

Our committee would like to recommend that some form of publicity be given to counteract the public hysteria during the polio season, by showing the relatively low contagiousness of the disease and its comparative infrequency in the population.

At the request of the Publicity Committee our Committee suggests that the executive secretary of the Indiana State Medical Association send a letter to WFBM & WFBM-TV expressing appreciation of their generosity in providing radio and TV time for these programs during the year.

2. The Committee on Necrology. We commend



this Committee for its work and recommend that its report be adopted as published in the Handbook.

3. State Fair Committee. We wish to commend this committee for its fine work in arranging publicity, demonstrations and distribution of information to visitors of our state fair. We suggest that in the coming year some demonstration exhibit or distribution of material might be arranged for visitors to the State Fair to help combat the public hysteria during the polio season as we recommended above to the Committee on Publicity.

G. B. WILDER, M.D., *Chairman*,  
HUBERT T. GOODMAN, M.D.,  
N. A. HIBNER, M.D.,  
CLIFFORD H. JINKS, M.D.,  
MAX LONG, M.D.

#### HYGIENE AND PUBLIC HEALTH

DR. JAMES M. KIRTLEY, chairman, presented the following report, which was adopted section by section, with amendments as noted, on motions of Dr. Kirtley, with seconds by those indicated:

The following report is submitted to the House of Delegates of the Indiana State Medical Association by the Reference Committee on Hygiene and Public Health covering the reports of standing committees of I.S.M.A. referred to it and also the resolution submitted for its consideration.

1. Committee on Industrial Health. The monumental work on "Medical Directives for the Nurse in Industry" accomplished by this committee and distributed throughout Indiana and studied with favor by industrial medical organizations throughout the United States is to be highly commended. The foregoing publication in addition to the leaflet entitled "Compensation Schedule for Particular Results of Injuries" gives evidence of much painstaking work on the part of the committee. (Motion for adoption of this section seconded by Dr. Harry P. Ross.)

2. Committee on Cancer. We wish to concur with the conclusions of the Committee on Cancer that information on this problem is not now handled as efficiently or well as it might be. It is felt that groups studying the cancer problem in the A.M.A., the State Medical Association and County Societies should correlate their work with their opposite numbers in the American Cancer Society, the Indiana branch and the county branches of the cancer society. Physicians should be urged to cooperate in every way so that the professional viewpoint may be given its proper place in dissemination of information on cancer. (Motion for adoption of this portion seconded by Dr. George R. Daniels.)

3. Committee on Chronic Illness. The committee is to be commended on its activities in conjunction

with the Governor's Committee on Chronic Illness in helping formulate and disseminate information to the public designed to curtail the ravages of chronic illness. (Motion for adoption of this section seconded by Dr. Daniels.)

4. Committee on Diabetes. The work of the committee in the annual diabetes detection drive has again shown excellent results in discovering new cases of the disease. Members of the Indiana State Medical Association are urged to cooperate with the drive for 1952 which will take place the week of November 16 to 22. (Motion for adoption of this section seconded by Dr. Daniels.)

5. Committee on Foot Hygiene. No report was submitted by this committee.

6. Committee on Hard of Hearing. No meetings were held and no report was made by this committee.

7. Committee on Heart Disease. This committee has cooperated in the preparation of material for public distribution concerning low sodium diets in heart disease. This work is considered very excellent and the committee should be commended for it. (Motion for adoption of this section seconded by Dr. Daniels.)

8. Committee on Infantile Paralysis. Although no formal meetings of this committee were held during the year, members did attend conferences held at the Indiana State Board of Health in cooperation with other professional and lay groups. Study was made of ways and means of combatting possible polio epidemics in Indiana. (Motion for adoption of this section seconded by Dr. Daniels.)

9. Committee on Mental Health. Your reference committee disapproves the report of this committee and recommends further study. We move that this portion of the report be adopted. (Seconded by Dr. Daniels.)

10. Committee on School Health and Physical Education. Several interesting questions were proposed in the published report of this committee in the Handbook which were to have been discussed at the September 23, 1952 meeting of a state-wide conference on school health. Your reference committee feels that it would be well to list in a subsequent report some of the findings on such questions as "Are Immunization and Physical Examinations School Health Problems?" and "What's Required in a Good Practical Screening Program?" The standing committee should be encouraged to continue its work. (Motion for adoption of this section seconded by Dr. Daniels.)

11. Committee on Traffic Safety. The report of the committee as reported is approved. (Motion for adoption of this section duly seconded.)

12. Committee on Tuberculosis. No report was submitted.

13. Committee on Venereal Disease. The report of the committee is approved. (Motion for adoption of this portion seconded by several.)

14. Resolution on Appointment of a Pathologist as a Member of the Indiana State Board of Health. Your reference committee approves of the resolution as submitted except for the last paragraph beginning "Be it further resolved—" and proposes the following substitution, to-wit: Be it further resolved that the Governor be informed that the Indiana Association of Pathologists will be pleased to submit a list of qualified pathologists for his consideration. (Motion for adoption of this portion of the report seconded by Dr. Elton R. Clarke.)

#### Discussion

Dr. Kirtley read the entire resolution. Following discussion by Drs. Minor Miller, Jack E. Shields, Maurice E. Glock, Lester H. Hoyt, John M. Paris, Harry P. Ross, Dr. Glock's motion that the resolution regarding the appointment of a pathologist as a member of the Indiana State Board of Health be tabled and that section 14 of the report of the Reference Committee on Hygiene and Public Health be not adopted was seconded by several, and passed.

Dr. Kirtley's motion that the report as amended, and signed by the following reference committee members, be adopted as a whole, was seconded by Dr. Bibler, and passed.

JAMES M. KIRTLEY, M.D., *Chairman*,  
A. A. THOMPSON, M.D.,  
PAUL R. TINDALL, M.D.,  
ROBERT O. ZINK, M.D.,  
JACK E. SHIELDS, M.D.

#### AMENDMENTS TO CONSTITUTION AND BY-LAWS

DR. CLAUDE S. BLACK, chairman, presented the following report, which, on motions of Dr. Black, with seconds by Dr. Daniels, was adopted section by section and as a whole.

Your Reference Committee on Amendments to Constitution and By-Laws has carefully considered the proposed amendment to the Constitution abolishing the office of alternate councilor as printed on page 19 of the Handbook. We recommend that this amendment do not pass.

The Committee considered the resolution regarding Section 4 of Article IV of the Constitution concerning senior membership as printed in the Handbook on pages 21 and 22. We recommend this resolution be stricken from the minutes and that such amendment be not further considered by this House of Delegates.

Mr. President, I move you the adoption of this report of the Reference Committee as a whole.

CLAUDE S. BLACK, M.D., *Chairman*,  
S. D. MALOUF, M.D.,  
PAUL N. CASEBEER, M.D.,  
HARRY P. ROSS, M.D., *Secretary*,  
D. S. MEGENHARDT, M.D., *En Absentee*.

#### REPORTS OF OFFICERS

DR. G. O. LARSON, chairman, presented the following report, which on motion of Drs. Larson and Daniels, was adopted:

The Reference Committee on Reports of Officers has read and carefully considered the address of the President, the address of the President-elect, the report of the Executive Committee, the report of the Treasurer, the report of the chairman of the Council, the reports of the councilors, the report of the Executive Committee, the report of the Woman's Auxiliary, the report of the Auditing Committee, and the report of the editor of THE JOURNAL.

It is the opinion of the members of this committee that these addresses and these reports indicate that the affairs of our state association have been in the hands of extremely competent, faithful, and loyal individuals, that our association during the past year has exhibited a healthy growth, both financially and in the service which it has rendered the cause of organized medicine and every individual member of the association. It is the desire of this committee to commend the official family of the Indiana State Medical Association for a job well done.

With reference to paragraph six in the report of the Executive Secretary on page 35 of the Handbook, the committee recommends that each delegate personally communicate with both Indiana senators and with his respective representative, calling attention to the danger inherent in Senate ratification of treaties such as the one proposed by the International Labor Organization. Furthermore, each delegate should carry this message to the members of his county medical society, urging them to contact the senators and representatives for the same purpose.

With regard to paragraph six in the report of the editor of THE JOURNAL on page 115 of the handbook, it is the feeling of this committee that the suggested service of publishing home and office telephone numbers in the year book roster would be superfluous and would be of aid chiefly to the telephone company.

G. O. LARSON, M.D., *Chairman*,  
F. R. N. CARTER, M.D.,  
JOHN M. PARIS, M.D.,  
FLOYD A. BOYER, M.D.,  
V. L. TURLEY, M.D.



## MISCELLANEOUS BUSINESS

## DISCUSSION

DR. WILLIAM C. REED, chairman, presented the following report, which was adopted section by section, with amendments as noted, on motions of Dr. Reed, with seconds by those indicated:

Dr. Neill Garber and his Committee on Convention Arrangements are to be commended on the excellent work they have done in providing a most delightful program of entertainment for this convention. We wish to extend the sincere thanks and appreciation of this House of Delegates to this committee for its efforts in making this a most successful and hospitable meeting. (Motion for adoption of this portion seconded by Dr. Daniels. Dr. A. G. Blazey moved that the Woman's Auxiliary be included in this section of the report. Motion duly seconded, and carried.)

*Report of Committee on Civil Defense.* Your reference committee commends this committee for its great activity, its numerous meetings, and its well organized plans. We recommend that this report be accepted as printed. (Motion for adoption of this section seconded by Dr. Daniels.)

*Report of Committee on Conference of County Medical Society Officers.* Your committee commends the Committee on Conference of County Medical Society Officers for conducting a very successful meeting in March of '52. The meeting was well attended and for the first time the majority of those present participated in the general discussions.

*Report of Indiana A.M.A. Coordinating Committee.* Your reference committee approves the recommendation made by the chairman of this committee, namely: that this committee be abolished and the president-elect appoint a committee to function in its stead. (Motion for adoption of this section seconded by Dr. Daniels.)

*Committee on Indiana Inter-Professional Health Council.* No report was received because this Council meets every other year and it did not meet this year.

*Committee on Military Manpower.* The reference committee recommends approval of this committee's report as published in THE JOURNAL and the Handbook. (Motion for adoption of this section seconded by Dr. Bibler.)

*Report of Committee on Veterans' Affairs and Rehabilitation.* The reference committee concurs in the recommendation of the Veterans' Committee that medical and hospital benefits not be extended to veterans with non-service connected disabilities. (Motion for adoption of this section of the report seconded by Dr. Nafe.)

Following discussion by Mr. Thomas A. Hendricks, Drs. Bibler and Truman E. Caylor, Dr. Bibler moved "that this resolution be referred to the standing committee for further study." (Motion seconded by Dr. Elton R. Clarke.) Discussed further by Drs. Jack E. Shields, F. S. Crockett, R. W. VanBokkelen, Robert Rang, John Palm, Philip Reed and R. L. Sensenich, following which Dr. Caylor moved "that the House adopt a substitute motion saying in one way or another that we vote this thing down." (Motion seconded by Dr. Palm.)

Dr. Bibler withdrew his motion, with the consent of Dr. Clarke. Dr. Caylor then offered the motion "That the House of Delegates disapprove of this section of the report of the Reference Committee on Miscellaneous Business." (Motion seconded by Dr. Bibler, and carried.)

Dr. A. G. Blazey moved "That a committee be named by the incoming president to meet with representatives of the service organizations to discuss this situation and to come up with some concrete solution to this problem." (Motion seconded by several.)

Dr. Rang moved that Dr. Blazey's motion be amended to the effect "That the House of Delegates shall express its desire that the presently existing veterans committee confer with the leaders of veterans organization to solve this problem and to confer with the proper committees of the American Medical Association." Dr. Rang's motion was duly seconded, and passed.

Dr. Philip Reed moved that "The president of this association instruct this committee (Veterans) to hold a meeting at its earliest convenience and to draft a statement for the press that will set forth clearly that this organization is at no time desirous of gouging the soldier, or the veteran, but it does wish to correct certain practices that are derogatory to our system of government and to the standards of medical care. These practices, if not curbed, will in the end hurt the soldier and the veteran as well as their families." (Motion seconded by Drs. Nafe and Bibler, and carried.)

*Official Action on Dues Reduction.* Your reference committee feels that this is an inappropriate time to reduce the state dues, and it does not recommend the passage of this resolution. We concur with the recommendation of the Council on this question. (Motion for adoption seconded by Dr. Daniels.)

*Resolution requesting honorary membership.* We approve the resolution requesting honorary membership for Dr. Stefan Ansbacher. (Motion for adoption seconded by Dr. Daniels.)

*Resolution on Official Endorsement of Activities, Principles and Policies of Individuals and Organizations.* Your reference committee recommends

that this resolution be considered unfavorably. (Motion for adoption seconded by Dr. Rang.)

*Report of Committee to Study Special Medical Licensure.* This report is not printed and was not read at the first meeting of the House of Delegates; therefore I shall read it. This committee was appointed at the interim session.

The committee to study special medical licensure, authorized at the interim meeting of the House of Delegates, April 27, 1952, met in Shelbyville, Indiana, on October 5, 1952.

"This committee considered its objective to be the advancement of some legal plan to relieve the shortage of trained hospital personnel without weakening our present Medical Practice Act or in any manner limit the reciprocity/endorsement privileges of Indiana physicians.

"A recommendation for new legislation was considered and rejected after it was learned that a committee of the Board of Medical Registration and Examination of Indiana, undertaking a similar study, was proposing the following ruling for adoption:

"That graduate medical students registered in hospitals licensed under the laws of the State of Indiana shall be considered as "trainees," and may study medicine, surgery, and obstetrics under the immediate and direct supervision of licensed staff members of such hospital for a period not to exceed one year; and shall not be considered as practicing medicine. Nothing in this ruling shall be construed as applying to regular internships and residencies in such hospitals."

"Your committee recommends the approval of this proposed ruling and prays its adoption by the Board of Medical Registration and Examination of Indiana.

(Your reference committee approves the first portion of this report referring to trainees, and I move the adoption of this section of the report.) (Motion duly seconded.)

Continuing with the report:

"Your committee further learned that the foregoing named Board would consider a change in its 'rule governing examination and licensure for graduates of schools located outside the United States and its possessions.' This change would permit the foreign graduate to *either* repeat the senior year in an approved United States medical school or, present documentary evidence, satisfactory to the Board of Medical Registration and Examination of Indiana, of having completed a

minimum of two years of post-graduate work (subject to approval of the Board) in a hospital located in the United States, which is approved by the Council on Medical Education and Hospitals, of the American Medical Association.'

"Your committee recommends the approval of this ruling and prays its adoption by the Board of Medical Registration and Examination of Indiana.

PAUL R. TINDALL, M.D., *Chairman*,  
LALL G. MONTGOMERY, M.D.,  
ALBERT M. DONATO, M.D.,  
ALBERT STUMP, Attorney."

Your reference committee approves this portion of this report, and moves its adoption. (Motion seconded by Dr. Herman T. Combs.)

With the exception of the section which was disapproved, I move acceptance of the report as a whole. (Seconded by several.)

WILLIAM C. REED, M.D., *Chairman*,  
JOHN S. HASH, M.D.,  
EARL W. MERICLE, M.D.,  
RAYMOND CALVERT, M.D.,  
GEORGE S. ROW, M.D.

#### PREPAID MEDICAL INSURANCE

DR. MAURICE V. KAHLER, chairman, presented the following report:

This committee met on Tuesday, October 28, 1952, to consider the report of the Permanent Study Committee on Medical Care Insurance as set forth in the Handbook of this Session, pages 100 to 102.

The subject of that report was the question of Indiana State Medical Association recommending to Blue Shield the payment of separate checks to the surgeon and to the participating physician in connection with procedures covered by Blue Shield Certificates of Membership, where the particular procedure was performed by a surgeon and another participating physician. This matter had been presented to the House of Delegates in the Interim Session on April 27, 1952, and in that Session the plan for issuing two checks when desired was recommended in cases of surgery where a participating physician is used.

The hearing by our committee in this session presented a picture radically different from that presented in the hearing on April 27, 1952. In the



April 27th meeting the hearing room was packed full, with many physicians standing in the entrance to the room and quite a number out in the hall who were unable to get into the room. Many physicians spoke on the subject, and practically all were in favor of it. In the session on October 28th only about ten persons appeared before the committee and spoke on the subject. The majority of these ten were Directors of Blue Shield.

Comments were made upon the additional costs that would be incurred with the two check plan, although this was a matter which appeared to the committee to be only a very uncertain estimate, for no one could anticipate how many cases there might be in which a participating physician rendered services and would claim compensation from the indemnity paid by Blue Shield. The highest estimates did not seem to the Committee to be enough to outweigh the desire of the medical profession as expressed in the vote on April 27th on this same subject. The Committee regarded itself as bound to take into consideration not only what was said by those who appeared before the Committee but also the vote that had been taken on April 27th and what had been said by the large number of physicians who appeared before the Committee on that date and expressed their views.

After hearing all who appeared before the Committee to speak upon the subject, the Committee itself discussed the question at some length.

It was the unanimous opinion of the Committee that the plan cannot succeed without the earnest, active and sincere cooperation of the entire medical profession in Indiana. This cooperation will require the making of proper reports and the agreement between the surgeon and participating physician regarding the amount each should receive from the indemnity to be paid under the Schedule of Indemnities. After discussion was completed Dr. Marshall of our Committee moved that the following resolution be adopted:

RESOLVED, That this Reference Committee recommends that Indiana State Medical Association request that Blue Shield try out a plan under which two checks may be issued where desired by the physician performing any surgical procedure; that the period for the trial of the said plan shall be for six months beginning April 1, 1953, and that Blue Shield be requested to report on the operation of the plan to Indiana State Medical Association at the end of the six months period; and that the plan include the following: That where the two check system is used the two physicians involved join in the reporting of the claim and each submit his own separate bill in an amount agreed upon between the two physicians, the total of which two bills shall not exceed the

amount of indemnity provided for in the Blue Shield Schedule of Indemnities for the surgical procedure performed by them.

The motion was seconded by Dr. Woner, a member of the Committee, and was unanimously carried.

Attention is invited to the fact that under this Resolution, if the plan is put into operation by Blue Shield, there would be no requirement that the surgeon and a participating physician make the report of their claims on this two check basis. They could proceed in the same manner now available: That is, the surgeon could make the report without the participating physician joining in it, and Blue Shield could send the check to the surgeon, who could then pay out of that check to the participating physician for whatever services the latter rendered. The plan as contained in this report would in effect be permissive but not mandatory.

MAURICE V. KAHLER, M.D., *Chairman*,  
C. F. BRIGGS, M.D.,  
W. M. STOUT, M.D.,  
JOHN WONER, M.D.,  
S. T. MILLER, M.D.

Mr. Chairman, I move that this report be approved and that the resolution incorporated within it be adopted as a resolution of the Association. (Motion duly seconded, and carried.)

#### RESOLUTIONS OF APPRECIATION

DR. RALPH EVERLY presented the following resolution, which was adopted unanimously:

"RESOLVED, That the secretary prepare a statement of thanks and appreciation to be sent to the proper representatives of radio, television, and the wire and press services for their excellent coverage of this 103rd annual convention."

DR. WILLIAM C. REED, chairman of the Reference Committee on Miscellaneous Business, presented the following resolution, which was adopted unanimously:

"Your reference committee wishes to express the unanimous feeling of appreciation of this House of Delegates for a most successful year under the leadership of our president, Dr. J. William Wright. His untiring efforts and hard work during the past year deserve the sincere thanks of this House of Delegates."

DR. JOHN PARIS' motion that the State Board of Health be thanked for its assistance and help in procuring speakers for the program for this convention was adopted unanimously.

DR. CLEON A. NAFE'S motion that the headquarters office be complimented on the excellent

work done on the Handbook was duly seconded and passed.

It was taken by consent that appropriate greetings of the House of Delegates be sent to Drs. A. M. Mitchell, Terre Haute; A. P. Hauss, New Albany; J. T. Oliphant, Farmersburg, and Jon Kelly, LaPorte.

**THE CHAIRMAN:** We have two distinguished visitors who have just arrived: Dr. R. Haynes Barr, of Owensboro, Kentucky, president, and Mr. Joseph P. Sanford, Louisville, executive secretary, of the Kentucky State Medical Association.

#### RESOLUTION TO HONOR

**DR. GEORGE F. AMES, EATON, INDIANA**

**DR. CLAY BALL,** Muncie, moved the adoption of the following resolution which was passed on October 21 by the Delaware-Blackford County Medical Society:

WHEREAS, Doctor George F. Ames has practiced medicine continuously in the town of Eaton, and in the surrounding country in the State of Indiana, for the past seventy-one years; and

WHEREAS, during those seventy-one years Doctor Ames has not only served the sick and injured, but has also delivered nearly four thousand babies without a single maternal mortality; and

WHEREAS, such years of service to the people of one community represents the highest achievement in the practice of medicine. Now,

*Therefore Be It Resolved* that the Indiana State Medical Association duly assembled in its one hundred and third annual session, and which is proud to hold Doctor George F. Ames as one of its honorary members, does hereby join in doing honor to one, who by his achievements of long and faithful service in the practice of medicine has acquired the respect and grateful affection of the members of his community, and has brought dignity and honor to the profession of medicine in our State and country; and

*Be It Further Resolved* that a copy of this resolution be spread upon the minutes of this meeting, and a copy, suitably inscribed and framed, and signed by the officers of the Association, and with the Great Seal of the Association affixed, be presented to Doctor Ames as a memento of the high esteem in which he is held.

Dr. Ball's motion was duly seconded and passed.

**THE PRESIDENT:** I want to take this opportunity to thank you for this honor you conferred on me two years ago by electing me president. It has been a distinct pleasure and I have enjoyed it very much. I know you will enjoy working with my successor. Thank you very much.

No further business appearing, on motion of Dr. George Daniels, duly seconded, the House adjourned *sine die*.

#### GENERAL PRACTICE SECTION

October 29, 1952.

Dr. C. C. Herzer of Evansville, Chairman, called the meeting to order at 2:00 p.m. with approximately 75 members in attendance.

A panel discussion on "Health Insurance as It Relates to the General Practice" was moderated by Dr. Maurice V. Kahler of Indianapolis. Members of the panel were Drs. Lester D. Bibler, Indianapolis; Walter L. Portteus, Franklin; D. D. Dickson, Greensburg; Wemple Dodds of Crawfordsville, and Mr. R. Saylor of Blue Shield and Mr. Guy Spring of Blue Cross as participants. Audience questions were answered.

The second item in the program was a paper on "Hospital Relationships for General Practitioners" by Dr. Maurice V. Kahler of Indianapolis. Dr. W. D. Gatch, Indianapolis, discussed Dr. Kahler's paper.

Dr. Herzer called the annual business meeting to order. Called on Dr. Norman R. Booher, Secretary, to read the minutes of the 1951 meeting, which were submitted by Dr. B. E. Edwards of South Bend, the then Secretary. The Secretary read the minutes and they were accepted as read.

The Chairman called for nominations for officers of the Section for 1952-53.

Dr. Lester D. Bibler, Indianapolis, nominated Dr. B. E. Edwards, South Bend, for Chairman.

Dr. Charles Alvey, Muncie, nominated Dr. Norman R. Booher, Indianapolis, for Vice Chairman.

Dr. O. T. Scamahorn, Pittsboro, nominated Dr. Frank Green, Rushville, for Secretary.

Dr. Jones, Indianapolis, moved that nominations be closed. Passed.

Dr. Edwards declared elected Chairman, Dr. Booher, Vice Chairman, and Dr. Green, Secretary.

Chairman announced that film sent from A.M.A. would be shown. This film was one prepared by West Coast labor groups for general distribution and vilifies the medical profession.

#### COMMITTEE ON PUBLICITY

October 10, 1952.

Meeting called to order at 4:15 p.m.

Present: D. S. Megenhardt, M.D., chairman; J. O. Ritchey, M.D.; Homer G. Hamer, M.D., and Jas. A. Waggener, executive secretary.

Minutes of the meeting held September 12, 1952, were read and approved.

The following "Hints on Health" columns were read and approved:

Week of November 10, 1952—"It's in Your Head."

Week of November 17, 1952—"Hip Fractures."

Week of November 24, 1952—"Careless Parents—Injured Children."

Week of December 1, 1952—"Convulsions."

The Committee approved the newspaper releases "General Convention Story" and "Story on Speakers."



## COUNCILOR DISTRICT MEETING

### SEVENTH DISTRICT

Doctors and their wives from Johnson, Marion, Morgan and Hendricks counties attended the annual fall session of the Seventh District Medical Society in Franklin on October 22. Registration totaled 130.

Afternoon sessions of the district society and the auxiliary were held in the Hillview Country club. Doctors enjoyed golfing and bowling in the early afternoon followed by a business meeting at 5:30 o'clock. Auxiliary members were guests at a tea and talk on interior decorating. They also heard a brief talk by Mrs. Hubert T. Goodman, Terre Haute, state auxiliary president.

At the banquet in the Franklin College Student Center, the day's program was climaxed by a talk by William Alan Richardson, editor of "Medical Economics"; a brief address by Dr. J. William Wright who thanked the district group for their cooperation during his year as president of the Indiana State Medical Association, and the introduction of the newly elected officers of the district. Dr. Ralph V. Everly, Indianapolis, was installed as the new president by Dr. William D. Province, Franklin, who served in that capacity during the last year. Other officers are: Dr. Elmer Koch, Danville, president-elect; and Dr. T. V. Petroneff, Indianapolis, secretary-treasurer.

## LOCAL SOCIETY REPORTS

Fourteen members of the **Clark County Medical Society** met in the Nurses home of Clark County Memorial hospital in Jeffersonville, October 21 when they held a general round table discussion of medical problems, approved their constitution and viewed the film "Backfire."

Thirty-three members of the **LaPorte County Medical Society** heard a paper on "Toxicology and Pharmacology of Explosives" at their October 16 meeting in the Kingsbury Ordnance Plant at Kingsbury. Dr. B. C. Giel was the speaker. During the meeting the membership of Dr. Donald A. Zalac was transferred from Indianapolis Medical Society to the LaPorte County society

The **Lawrence County Medical Society** held a noon luncheon in Dunn Memorial hospital, Bedford, with 16 members present. Dr. Donald M. Kerr gave a comprehensive report on the Annual Session of the Indiana State Medical Association after which they saw the film "Health, the American Way."

The **Dubois County Medical Society** held a dinner meeting on October 9 in the Knights of Columbus hall in Jasper at which time Robert J. Amick, field secretary of the Indiana State Medical Association, spoke on "Problems Before the Medical Profession."

There were 12 members present. The next meeting is scheduled for December 11 at 6 p.m. in Huntingburg.

The staff of the Harrison County hospital met November 6 in the hospital and following a brief business meeting adjourned and held a Harrison County Medical society meeting with eight members present. Dr. William E. Amy, Corydon, gave a report on the I.S.M.A. convention and the society voted permission for the formation of an Auxiliary to their organization.

Dr. John R. Brayton, Indianapolis, was the guest speaker at the October 8 meeting of the **Bartholomew County Medical Society** which was held in the Country club in Columbus. Dr. Brayton's subject was "Skin Diseases in the General Practice."

Dr. Charles F. Leich, Evansville, gave a paper on "Respiratory Difficulties of the New Born" before 17 members of the **Gibson County Medical Society** at their November 10 meeting in the Elks Home in Princeton. Preceding the dinner, the film "Health, the American Way" was shown by Robert Amick, district field secretary for I.S.M.A.

Members of the **Cass County Medical Society** held a dinner meeting and transcribed telephone seminar on "Non-Surgical Affections of the Spinal Cord" on October 20 in the St. Joseph hospital, Logansport. Dr. Alexander Ross, professor of neurology, Indiana University Medical Center, served as moderator.

Members of the **Fayette-Franklin County Medical Society** held a dinner meeting November 11 in the Connersville Country club. Seventeen members were present and heard a brief talk by Robert Amick, I.S.M.A. field secretary.

Dr. Palmer Eicher, Indianapolis, was the speaker at an October 20 dinner-meeting of the **Madison County Medical Society** held in the Anderson Country club. Doctor Eicher spoke on "Surgery of the Hip Joint."

The November 12 meeting of **Bartholomew-Brown County Medical Society** was held in the Harrison Lake Country club at which time the group saw a film on "OB Anesthesia." Dr. T. D. Carpenter, Columbus, president of the two-county society, has been recalled to the Navy and the vice-president, Dr. Robert B. Hart, has assumed his duties.

Members of the **Boone County Medical Society** met in Witham Memorial hospital, Lebanon, to participate in a telephone seminar on October 7. Nine doctors were present. During the meeting Mr. R. M. Malpas, Lebanon Country club, presented a resurcnette to the hospital.

Dr. C. O. McCormick, Sr., Indianapolis, was the guest speaker for the **Wayne-Union County Medical Society** meeting on November 13 in the Leland hotel, Richmond. Dr. McCormick spoke on "Pre- and Post-Marital Instruction." Thirty-three members attended the dinner meeting.

A dinner meeting of the **Putnam County Medical Society** was held on November 14 in the DePauw Union building with 12 members attending. Following a short business meeting, the members heard two wire recordings—"The Complications and Sequelae of Acute Myocardial Infarction" and the telephone seminar of last April on "Cancer." A brief outline of the services available through the Indiana State Medical Association was given by Robert Amick, field secretary.

## WOMAN'S AUXILIARY

to the

*Indiana State Medical Association*

**President—Mrs. Hubert T. Goodman, Terre Haute**

**President-Elect—Mrs. Burleigh Matthew, Indianapolis**

**Corresponding Secretary—Mrs. B. M. Merrell, Rockville**

**Recording Secretary—Mrs. Charles Richardson, Rochester**

**Treasurer—Mrs. J. M. Sullivan, Terre Haute**

**Publicity—Mrs. F. M. Gastineau, Indianapolis**

The Ninth Annual Conference of State Presidents, Presidents-elect and National Committee Chairmen was held in Chicago, November 6 and 7, in the ballroom of the LaSalle hotel.

The conference presiding officer was Mrs. Leo J. Schaefer, national president-elect, and Mrs. Ralph W. Fowler of Georgia was elected conference secretary. The theme of the meeting was *Our Goal—a Better World*.

Indiana was represented by Mrs. Frank Gastineau, national chairman, American Medical Education Foundation; Mrs. Lester Bibler, regional Civil Defense chairman; Mrs. Francis M. Fargher, regional organization chairman; Mrs. W. Burleigh Matthew, state president-elect, and Mrs. Hubert T. Goodman, state president. Panel discussions were grouped under *You Are the Auxiliary* (Organization and Bulletin); *The Obligation Is Ours* (Program, Mechanics of a convention, Nurse Recruitment and Civil Defense); *It's Your American Medical Association* (Today's Health, American Medical Education Foundation, Library Service, World Medical Association, reports from directors of Blue Cross and Blue Shield); *Joining Forces for Community Service* (Public Relations, Legislation); *Where Your Dollars Go* (Auxiliary Finances), and in summary, *This We Have Done* (History of National Auxiliary).

Indiana received recognition for the excellent quality of its program kit and the material included and special note was made of the Perry County program as an example of what a small Auxiliary can do. (100 per cent membership, 11 members.) Mrs. Bibler and Mrs. Matthew appeared in a Civil Defense skit.

Luncheon speakers were outstanding—Mr. Arthur L. Conrad, president of Heritage Foundation, was the guest Thursday, and Indiana's Mrs. Oscar Ahlgren, president of the General Federation of Women's Clubs, appeared on Friday. Addresses during the conference that were exceptional were presented by Dr. Ernest B. Howard, assistant secretary of the A.M.A., and Mr. Thomas Hendricks, secretary, Council on Medical Service, A.M.A.

A tour of A.M.A. headquarters was scheduled for Friday afternoon after adjournment. The Auxiliary officers and committee chairmen were guests for the annual dinner Friday night, with the A.M.A. Board of Trustees as hosts.



*THE JOURNAL*  
OF THE  
*INDIANA STATE MEDICAL ASSOCIATION*

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

E. M. SHANKLIN, M.D., Hammond, Editor Emeritus  
FRANK B. RAMSEY, M.D., Indianapolis, Editor  
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